DOCUMENT RESUME

ED 154 977 RC 010 548

TITLE Guidelines for Gathering Cross-Cultural Information.
INSTITUTION Public Health Service (DHEW), Washington, D.C. Div. of Indian Health.
PUB DATE Apr 70
NOTE 15p.; Not available in hard copy due to small print size of original document

EDRS PRICE MF-$0.83 Plus Postage. HC Not Available from EDRS.
DESCRIPTORS *American Indians; Communication Problems; Community Attitudes; *Community Surveys; *Cross Cultural Studies; Cultural Differences; *Data Collection; Field Interviews; *Guidelines; Health Services; Interviews; Personnel Selection

ABSTRACT

The planning, implementation, and evaluation of a comprehensive health program creates a continuing demand for concise and accurate information of many types. The major source of some of the most pertinent information is the American Indian people, the recipients of health services. Gathering the required information is complicated by communication barriers produced by cultural differences. However, a group's culture will be expressed by several patterns of behavior. When observed, or brought out by survey and interview, they may appear to be inconsistent. Therefore, an accurate interpretation of the information received requires a knowledge of behavioral patterns and how these patterns are expressed. This guide presents some guidelines for gathering cross-cultural information. Discussed are the field survey and techniques used, a systematic approach to gathering information, information sources, cultural patterns, community attitudes toward providing information, communication barriers, interview preparations, establishment of Tribal and Service Unit support, the project's objective and scope, organization of a field survey, survey staff and functions, selection and training of interviewers, the questionnaire and interview schedule, interview techniques, and the final reporting and interpretation. A 20-item annotated bibliography is appended. (NQ)

GUIDELINES FOR GATHERING CROSS-CULTURAL INFORMATION

OFFICE OF PROGRAM DEVELOPMENT * INDIAN HEALTH SERVICE
PUBLIC HEALTH SERVICE
HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION
U.S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

PREFACE

The Indian Health Service was organized in 1955. The initial priority was placed on overcoming critical staff shortages and facility deficiencies. By the early 60's this thrust had developed momentum, and substantial gains had been made. It was becoming increasingly apparent however, that staff and facility resources would never be adequate to fully meet Indian Health needs if the delivery of health services continued to be based on traditional and outmoded organizational patterns in the health field. This awareness brought about expanded efforts to improve the organization and management of health resources. Experience had also conclusively revealed that the effectiveness of health programs is directly related to the amount and type of involvement on the part of the health services consumer--the Indian people.

The centers for Training and Health Program Systems were established in Tucson, Arizona, for the purpose of increasing health resource effectiveness and Indian involvement. To further accelerate achievement of these goals, the Office of Program Development was created in July, 1969, bringing together within one organizational structure the Health Program Systems Center and the Desert Willow Training Center.

THE MISSION OF THE OFFICE OF PROGRAM DEVELOPMENT

1. Develop a systems approach to the delivery of health services. The over-all health system will be composed of a number of sub-systems and will be designed to make possible the following:

a) Integration of available medical treatment and prevention services required to meet the needs as identified by a consumer group.

b) Coordination of health services by the Indian people with all other community activities (education, economic development, housing, nutrition, and communications) so they can develop a concerted and balanced drive toward their objectives.

2. Develop human resources by providing training and related experiences to health staff and the Indian people. Human resource development has a dual focus.

a) provide and increase technical competency

b) accelerate the transition of program decision making from health professionals to Indian community residents.

The Office of Program Development therefore, is dedicated to the development of an approach that will incorporate health sciences, systems technology and community development principles into a unified and dynamic force.

INDIAN HEALTH SERVICE, HSMHA
EMERY JOHNSON, M.D., DIRECTOR

OFFICE OF PROGRAM DEVELOPMENT
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I.H.S.

TABLE OF CONTENTS

April 1970

INTRODUCTION

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Background

The planning, implementation, and evaluation of a comprehensive health program creates a continuing demand for concise and accurate information of many types. The major source of some of the most pertinent information is the Indian people, the recipient of health services. Gathering the required information is complicated by communication barriers produced by cultural differences. The Health Program Systems Center has made several field studies for the purpose of obtaining, from residents on the Papago Reservation, factual and objective information relating to health. These guidelines were prepared in response to requests that the methodology and techniques used be shared with all Indian Health Service personnel.

Adaptability

Inevitably there will be the very legitimate question of adapting the guidelines developed in the Papago setting to other Indian groups. It is anticipated this will not prove to be a significant problem for two reasons:

1. There are major areas of similarity common to all Indian groups. Although there are characteristics unique to each group, they are alike in more ways than they are different.
2. The guidelines are based upon principles of interviewing by health workers in the cross-cultural setting and, for this reason, should prove to have wide application.

The principles presented in the guidelines have proven to be applicable in informal one-to-one contacts as well as in the more formal and organized field surveys. For example, many health staff members, particularly those with several years of experience, will find they have discovered and daily utilize many of the principles and techniques described.

Field Survey Utilization

Field study utilization of the guidelines include:

1. A census of Indian residents of the Sells Service Unit, which included persons from other tribes as well as Papagos.
2. A description of the Papago medical philosophy, constructed through a linguistic analysis of the Papago concepts of health. Papago medicine men had a key role in this survey.
3. Health client attitudes toward the services of IHS and related socio-cultural information.

Techniques Utilized

Three field techniques were used in conducting the surveys:

1. House-to-house survey with a formal questionnaire.
2. Intensive interviewing of residents selected as being representative of the population.
3. Linguistic interviewing with a series of "elicitation frames" designed to translate the Papago medical concepts into English. This made possible a comparison of the health and medical care concepts and practices of the Indian Health Service and the Papago Indians.

A Systematic Approach to Gathering Information

One's first awareness of a culture other than his own will occur during childhood, and will take the form of random information. Some will be accurate, but in many instances the information will be superficial, inaccurate, and incomplete. These experiences will be accompanied by cues as to how one should react to the "information." The information forms an image of the culture within the mind of the observer. His own culture includes a value system that influences his conclusion about members of another cultural group.

Many people enter employment in a cross-cultural situation with the preceding as an orientation base. They will immediately experience a need both for additional background information as well as for specific information required to function effectively in their job. The natural tendency is to use the existing information as a framework, and view all additional information as details to be used in "rounding out" one's understanding (and image) of the cultural group.

It is soon found that this process doesn't work. There will be new information that not only doesn't fit with past information, but emerges as contradictory to some of the original information. The three most common reactions to this situation are as follows:

1. Deny the existence of the new information. If it doesn't exist then no action is required.
2. Develop two or more informational structures. This enables one to produce a description of the cultural group most compatible to the situation at hand.
3. Use a systematic apparoach for gathering and organizing cross-cultural information that is based upon logic and science.

This can be accomplished in the following manner:

Determine information needs. These needs will be of two types: broad over-all knowledge of the setting and of the people one works with, both Indian and non-Indian; and the very specific information required to plan and provide specialized health services.

Objectively identify and evaluate the source of all past and present information.

Employ the concept of information as a structure consisting of many parts. The design, therefore, must permit modification and additions (things do change).

Develop skill in gathering, evaluating, and organizing information.

All indications are that the use of the denial and multiple image approach is neither by intent or with the awareness of those who appear to pursue this route. It occurs only when there is limited knowledge of an approach based upon logic and science. The following sections emphasize a systematic approach to gathering cross-cultural information.

Information Sources

The search for information should begin by checking with the staff of organizations working with Indian groups (principally IHS and BIA), files within these organizations, and the library. This search can eliminate needless duplication of effort and may identify someone currently seeking the same or related information. Information similar to that desired may be available, and may require only a few corroborating questions to meet the current need.

When an article has been published on the same or a similar subject, one should read that article, and also contact the author. A person conducting field interviews will collect more information than he publishes. A visit or correspondence with this person may provide the needed information without a repetitious series of interviews. It is important to contact those who have published a census or statistical report, because the field forms from which the statistical information was taken will often contain other information useful to Service Unit staff.

Cross – Cultural Considerations

CULTURAL PATTERNS AND TERMINOLOGY

The culture of a group will be expressed by several patterns of behavior. When observed, or brought out by survey and interview, they may appear to be inconsistent. An accurate interpretation of the information received requires a knowledge of behavioral patterns and how these patterns are expressed.

Ideal and real patterns of culture:

Patterns of culture called "ideal" simply refer to the ways in which we think we SHOULD behave. "Real" patterns of culture describe the ways in which we DO behave. These differences are important to remember when comparing information gained through observation with that gained by asking. When someone watches us, they see our "real" behavior patterns. When they ask us, we usually describe our "ideal" behavior patterns. For example, one man may describe himself as a law-abiding driver; yet when he drives he always goes a few miles over the speed limit.

Ideal and real patterns of behavior must be remembered because the information provided in a health interview may conflict with the behavior observed in daily activities. Often the health worker becomes frustrated because he thinks people are not providing true information. The pertinent question is not whether the information is true or false, but whether it is "ideal" or "real". The ideal and real patterns of behavior occur side by side in all aspects of behavior.

Overt and covert cultural patterns

Readily observable *overt* patterns of culture are clothing, housing, modes of transportation, food, eating manners, speech patterns, and methods of greeting strangers and friends. *Covert* patterns of culture are personal values, religious beliefs, fears and attitudes to the opposite sex or a different age group. Obviously these patterns are not readily observable. Overt aspects of behavior can best be identified through observation; however, many aspects of covert behavior must be explained, and individuals do not readily provide information on covert behavior. It is important to be fully aware of the inherent difficulty of obtaining complete and accurate information about covert behavior patterns. For these reasons, considerable caution must be exercised in drawing conclusions or making predictions from this information.

Explicit and implicit cultural patterns

Explicit patterns of culture are those behavior patterns or aspects of one's beliefs that can be readily described to another person. One is conscious of these behavior patterns, knows what he is doing, and why he is doing it. For example, a very wise elder member of the Ute tribe was asked, "How does it feel to be a Ute?" After a period of silence he responded by asking, "When?" The discussion that followed revealed a keen awareness that his feeling (and therefore, behavior) was influenced by the situation at hand.

Implicit behavior patterns are those aspects of behavior which cannot be readily explained, and in many cases, of which one is not really conscious. The differences in one's attitude to an older or younger person, the manner of standing or speaking when conversing with another person, individual idiosyncrasies of speech or behavior, are all implicit aspects of behavior. A person who nervously fidgits while talking, or frequently uses the sound "uh" in his conversation, may be unaware of these habits. "Habit" is a word often given to aspects of implicit behavior, because these aspects of behavior are done with so little consciousness one is not even aware of them.

The important consideration between these two pairs of behavior patterns, over-covert and explicit-implicit, is that what is implicit to one individual may be overt to the person observing him. For example, a person may be unaware of fidgiting nervously when talking, and therefore will never mention this when describing his speech patterns to another person; however, the person to whom he is talking might be very aware of the fidgiting and be able to describe it in detail.

Awareness and consideration of these behavior patterns are pertinent to the health worker in cross-cultural situations. The individual may have no awareness of the behavior the health worker is interested in and is trying to alter. It is equally important for the health worker to understand that if implicit (habit) behavior is pointed out to an individual, he is now conscious of it and can explicitly describe it to another person. Remember: (1) behavior which is overt to an observer may be implicit to the person doing it; and (2) implicit behavior can become explicit behavior to an individual if it is pointed out by an observer.

Culture within a culture

Well established occupational groups will develop "cultural" patterns unique to those in the same occupation and setting. A situation such as the health needs of the Indian can present a demand for services that cannot be adequately met by following the patterns that have evolved in the middle class urban setting. Following is one example.

In the sub-culture or system of private medical practice, the individual grows up with a doctor who has been treating him and his family for many years. If he moves to another town, the individual or his parents locate a new physician. This is done either through the recommendation of the former, trusted doctor or through the advice of a friend or business associate. Past experience with public type medical care has usually been limited to a university health center or, in some instances, medical services provided by the military. The private physician is known and trusted, and the patient confides more readily in him. As a result the private physician has a sizeable background of information about the patient, his family, his attitudes, and fears. The additional information required to properly treat a current illness is usually minimal, and obtained quickly.

The health service doctor is one of many who may see the patient. There is seldom the opportunity to fully develop the rapport and trust the physician in private practice enjoys. The health service physician is largely dependent upon, and limited to, that which he sees on the chart. While the private physician and his office staff need only ask for information once, the health service staff must ask questions many times to obtain adequate information. Health service personnel familiar with the system of private medicine, and now employed in the system of public medicine, should remember these differences when gathering information about a patient.

The preceding comments are included only to indicate the existence of cultural patterns within a profession. As a further extension of this point, note should be made of the fact that the Indian Health Service is a comprehensive health program, and as such, brings together a number of professions, each with its own unique, professional way of life. Each must develop methods for meeting informational needs with both the health client and fellow staff.

COMMUNITY ATTITUDES TOWARD PROVIDING INFORMATION

The role of information gathering in the community should be considered, before beginning a field health survey, sample interviews, or clinic interviews. What type of information are community residents accustomed to giving about themselves and other members of their community?

In many middle class urban communities, residents are accustomed to responding to questionnaires or phone interviews, and are accustomed to providing opinions, attitudes, and comparisons. Residents of these communities often think in terms of comparison, and quickly assign adjectives to a series of choices. They daily make comparisons based upon, "this is better than that," "older or newer," and "larger or smaller." Television advertising emphasizes comparisons and selections between a variety of quite similar choices. The urban middle class resident is continually comparing himself, his family, his place of residence and work, his possessions, and his attitudes with those of people around him. The competition emphasized in the urban middle class way of life reinforces the continual comparison that enters into all thinking of urban residents. By contrast, many individuals not raised in the highly competitive urban middle class have not learned to think in terms of comparisons, or when asked, to express comparative views.

Before conducting interviews asking the individual to provide comparisons about health services or medical care, one should undertand the degree to which people in the community express themselves in terms of comparisons and the types of comparison they are accustomed to making.

Expressing opinions for another person

Much of the information in which the IHS is interested concerns various programs and attitudes towards the health delivery system. In the middle class urban setting an individual is frequently asked

to give opinions not only for himself, but also for other members of his family and his community. By contrast, many Indian people put high value on the autonomy of the individual, and would not think of expressing opinions for other members of the community and often not even for other family members.

Before asking questions which require an individual to provide information about other members of his family or community, one should be aware of the community's feeling about this type of information-giving.

COMMUNICATION BARRIERS

Often physicians working in the Indian Health Service are concerned that patients do not give them enough information to treat their health problem. Other members of the health team experience similar frustrations. This problem needs to be fully understood in each service unit providing direct services. The patient may not know what the physician considers necessary information.

Residents of non-Indian communities have long been accustomed to the clinical interview. Non-Indian children learn from listening to physician-parent discussions the types of information needed by the physician to properly diagnose and treat a health problem. Television advertising provides the individual with many descriptive terms to use when discussing his problem with his physician: a hammer and anvil beating in his head; acid dripping into his stomach; or Excedrin headache number 23. The physician also knows how to interpret many descriptive terms used to identify pain (throbbing, stabbing, sharp, dull, etc.). The patient knows he is expected to provide his physician with information concerning the location of his problem, length of time he has been bothered, frequency and seriousness of pain, type of pain, etc. This is part of the established patient-physician relationship typical of the predominant (non-Indian) culture.

This may not, however, be the pattern in many Indian communities. When gathering health information in a clinic and home setting, the staff should be aware that the patient may understand neither the type of information desired, nor the "Anglo language" ordinarily used in this type of situation. If such is the case, he obviously cannot provide the amount and type of information desired.

This situation is similar in some respects to the situation and feelings confronting the average middle class urban non-Indian if he were forced to consult a marriage counselor, thereby becoming a client for services in an area where he has had no previous experience. The non-Indian individual might feel embarrassment because his marriage problem cannot be solved within the family or with the advice of an older relative. The individual would probably have no idea what information is needed by the counselor to diagnose his marriage problem and advise him. The counselor would know, but his client would not. Is the counselor interested in the recent actions between the man and his wife, fights, arguments? Or is he interested in long-term differences based upon religion, attitudes toward child raising, etc.? This area, too, has its language. Both the client and counselor are more comfortable after the client learns and uses the terms common to counseling: for example, the husband's use of oedipus complex to help describe his feeling that his son is a momma's boy; a family fight verbalized as an expression of hostility; and the wife's description of husband's behavior as neurotic rather than nutty.

The client will be inclined to give very little information and to respond only to questions asked in this type of situation. When a person does not know exactly what is wanted, he tends to keep his mouth shut so he does not reveal facts about himself the interviewer does not need, are considered too personal to discuss with a stranger, or may be viewed as indications of weakness or ignorance. This tendency may prevent the client from providing health staff (social worker, health educator, physician, nurse) with information needed to adequately assist in overcoming the health problem.

Indian Health staff members are urged to consider whether they are adequately informing the Indian respondent of the type of information desired, and why the information is considered essential. An information deficiency from staff to the Indian respondent may inadvertently be the primary reason for an inadequate response.

Communication between the physician and patient is complicated when an interpreter is necessary.

iew Preparations

TRIBAL AND SERVICE UNIT SUPPORT

The first step is always directed toward bringing about a mutual understanding between the Service Unit Director and Tribal Chairman that the desired information is essential and not now available. The concurrence and support of these two people, plus others that may be appropriate (health committee, district representative, etc.) is required to meet administrative needs, and to assure the support required to make the project successful. Develop a written proposal that provides the information discussed in the following sections. The proposal should also identify any help desired from the Service Unit staff and the Tribal Government.

OBJECTIVE AND SCOPE OF THE PROJECTS

The answers to the following questions should determine the design of the information-gathering project, and be included in the project proposal submitted to the Tribal Chairman and Service Unit Director. These same questions must be answered in the training of the interviewers so they in turn can explain the project to the people being interviewed.

1. Why is the interview being conducted?
2. Why is this information needed?
3. What information is needed?
4. How will this information be used?
5. By whom will this information be used?
6. When will this information be used?
7. Where will this information be used?

Each of the above questions is discussed in the paragraphs that follow.

Why is this interview being conducted? When someone is asked to give his time answering questions in an interview, an explanation is due him. Why are we asking these questions? Can this information be gathered by any other means, and if so, have these means been tried? Has someone been too eager to get out into the community with a survey when the information needed has already been collected? The respondent should be told why he has been selected for an interview. Is the survey including all households in the community or is his household one of a selected sample? If it is a sample, he should be told the extent of the sample so he will have some idea of how many other people in his community will be included. In general, the health worker should be ready to tell the respondent why questions are being asked, why these particular questions, and why of him.

Why is this information needed? Is this information needed for planning in health programs, provision of direct care to the patients, for suppo[illegible] of grants to the community funded by a governm[illegible]nt agency or for general scientific interest? The explanation of why the information is needed should include how the information can be used to help him and his community.

What information is needed? Exactly what information is needed? Was a search made for any similar information collected previously? Have individuals been contacted who have conducted interviews in this community to see if their information might be used? Explain the action taken and results of checking out existing information (see information sources, page 1 of introduction).

How will this information be used? Will this information be used in a statistical manner or will individuals be clearly identifiable? Will this information be used to provide services to people in the community or as a basis for general planning? Will this information be available in the original interview forms or will it be transferred to punched cards? What information will be given to interested persons?

By whom will this information be used? Many people concerned about the confidentiality of information are reluctant to give full and accurate information if they are not sure who will use the information. It is necessary to clearly explain how the information will be organized and identified, and who will have access to it. Make a distinction between statistical reports or raw data without identification, and any information that will be available in its entirety, including the respondent's name and other identifying characteristics.

When will this information be used? The time periods of a study should be made clear to members of a community. Some types of information are for immediate one-time use, other types maintain their value over a long period of time, and other categories of information increase in value through regular up-dating. All of this should be explained.

Where will this information be used? The community participating in a series of interviews should be told where the information they are providing will be used. For example, will it be used by local agencies or is it to become part of a large scale base of information? Will it be used by agencies in the state, or by agencies and universities outside the state? How widely will reports developed from this information be circulated?

While all of the above questions may not seem necessary and not all of this information may be important to the community, it should be remembered that respondents in a survey, tribal officials, and health staff, have a right to the answers. Remember too, that individuals are not required to participate in interviews; they do so voluntarily. If a respondent can answer questions out of courtesy, the interviewer should show the same courtesy by being ready and able to fully explain what he is doing and why he is doing it.

SELECTION OF METHODS AND TECHNIQUES

A systematic approach to gathering information will utilize a survey questionnaire, an in-depth interview, or a combination of the two. Selection of the approach to be used should be based upon the answers to the preceding seven questions and an understanding of behavorial patterns as discussed in the section "Cross-Cultural Considerations", beginning on page 2.

The survey questionnaire and in-depth interview schedule are described on page 7.

Organization of a Field Survey

SURVEY STAFF AND FUNCTIONS

The organization of a field survey will vary according to the size of the population being surveyed. Differences will mainly be in the number of levels of organization used to accomplish the field work. The population to be surveyed for the Health Information System in the Sells Service Unit included approximately 9,500 individuals, of which 5,400 were reservation residents and 4,100 were off-reservation residents. This population was composed of approximately 1,100 reservation families and 900 off-reservation families. The levels of organization used in each of these field operations were, beginning with the level closest to the field:

a. Enumerators or interviewers
b. Field supervisors
c. Field coordinators
d. Field director
e. Project director

The enumerators or interviewers conducted survey interviews daily, in the reservation and off-reservation communities. The survey forms contained about thirty questions and usually required less than an hour to complete. The reimbursement of interviewers on a per-interview basis rather than an hourly basis enabled them to work at their own speed and develop a pleasant interview situation without the pressure of time.

The supervisors contacted each interviewer daily to collect field-forms and review for completeness. Incomplete forms are returned to the interviewer to be completed by a revisit to the respondent. Completed forms are forwarded to the coordinators.

Field coordinators maintained a smooth flow of forms from the communities to the field director. Completed forms received from supervisors were edited for final completeness by the coordinators and were then forwarded to the field director. The coordinators supplied the supervisors with new forms and with money to pay interviewers at the close of each week. The coordinators ensured smooth daily progress, transferring interviewers and supervisors from one area to another as field work was complete.

Both coordinators and supervisors conducted interviews themselves when they were not editing field forms or supervising field workers under their direction.

The field director was responsible for the entire field operation, maintaining control over the selection and training of interviewers, planning the field project, arranging finances for the field effort and overseeing the flow of questionnaires to the field and back into the project director's office.

The field director and the majority of individuals working under his direction were members of the Papago tribe. It is strongly recommended the field effort be directed and carried out by members of the tribe and community. They are familiar with the local people and know the characteristics required of an interviewer. They will also know how to handle special considerations or field problems. Experience has shown there are many individuals in the local communities qualified to carry out a field project. Bringing in outside staff is seldom necessary except to consult with in the construction of the questionnaires or to simplify data processing.

SELECTION AND TRAINING OF INTERVIEWERS

1. It is essential that interviewers be from, and acceptable to, the community. Selection should be made by the appropriate community organization if the study concerns problems coordinated or controlled by the community.

2. Age and sex are usually important considerations in the selection process. In many Indian communities, older women have been found to be the most successful interviewers because most contacts are with the women of the house.

3. Limit the number of interviewers. A small group of well-trained interviewers can work more efficiently and maintain closer contact with the supervisors and coordinators than can a large group.

4. Provide adequate initial and follow-up training.

5. The initial training is directed toward providing an understanding of the importance of the project as well as interviewing skill. Carefully explain to the interviewers the purpose of the interviews. Completely answer the seven questions discussed on page 5. Go over the questionnaire with each interviewer, explain the need for each question, and clear up any confusions over language or content. The interviewers should fully understand the interview and be aware of the need for each question.

6. Follow-up training is provided on the job and through group sessions with the survey staff. Accompany each interviewer into the field to observe his first few interviews. Discuss his interviewing techniques and advise him on any rough spots. Group sessions provide an opportunity to discuss problems occurring in the interview situations or with the questionnaire.

7. Interviewers must understand the importance of turning in completed forms each day for editing by the supervisor. If the interviewer is to return to a home to obtain missing information, he will find this easier if his return visit closely follows his original visit.

THE SURVEY QUESTIONNAIRE

Keep the form as short as possible. Determine the minimal amount of information required to achieve the objective of the survey. Eliminate all other subject matter and questions.

The temptation to "piggy back" one study on another should be avoided. Expansion of the health survey to meet unrelated needs will diffuse the primary effort and confuse respondents. An interview restricted to basic necessary information is more easily explained to members of the community, which in turn makes it easier for them to provide the information required.

Each question must be clear and concise. Clarity is achieved by determining the educational and reading level of the community and the elimination of technical jargon, ambiguous terms and long words.

A concise question helps to obtain a concise answer. A long rambling question will usually stimulate a "like" response. If the question requires an explanation, provide this information verbally as an introduction – don't combine an explanation and a question.

It should also be recognized that an abbreviated question may lose the meaning of the full question. For example, an effort was made to shorten several questions used in a census survey. Field testing revealed the meaning was lost and the responses were confusing. The question, "Where else have you lived during the past year?" was useless when shortened to "Other residences?" The responses to "other residences" brought information concerning both mobility and home ownership; whereas the question was designed to obtain information concerning mobility.

Avoid questions requiring a judgmental response. This type of information is best obtained through the in-depth interview. For example, the project may be directed toward determining community attitudes about clinic services. The questionnaire is an excellent device for establishing the amount and type of service, i.e., "Have you gone to the clinic in the past year?" If yes, then "How many times have you gone to the clinic during the year?"_____.(Number) "Why did you go to the clinic?" Response to this question can be recorded on a check off list such as:

- ☐ Respondent ill
- ☐ Pre-natal
- ☐ Accident
- ☐ Immunization
- ☐ Well baby clinic

At this point one should shift to an in-depth interview as described under the heading of "The Interview Schedule." Remember, an agreement to participate in the interview is evidence of cooperation – he wants to help. A question such as, "Were services good" has the effect of providing a cue and pointing the respondent in the "good" direction. His desire to help may cause him to search for a "good" answer rather than examining his own feelings. By the same token, a question including the word "problem" will be interpreted as a search for problems and will often provoke a "problem" response.

Thoroughly test the questionnaire and questions. The initial test should be made internally with both Indian and non-Indian staff. An obvious benefit will be their contributions to the questionnaire design. An additional and equally important by-product is the understanding of, and involvement in, the project achieved through their participation. Next, field test the final draft of the questionnaire. This test should utilize respondents selected to provide a cross section of the group to be interviewed.

THE INTERVIEW SCHEDULE

An interview schedule is used in the in-depth interview. The schedule consists of a series of open-ended questions asked by the interviewer. The respondent is *directed to the topic* by the question. The question is also designed to be neutral or *non-directive within a topic*. For example, "How do you feel about the clinic?" provides a full spectrum of choice; whereas, "Do you feel the clinic meets community needs?" has the effect of demanding a yes-no answer and limiting response to a support of that conclusion.

The initial response will often require clarification to be meaningful. The subsequent dialogue places a demand upon the interviewer to be neutral and non-directive. Role playing during the training period is an excellent device for helping the interviewer develop these capabilities.

Field use of the interview schedule should be preceded by a review with staff, and field testing. In addition, a cross-check between reports from different interviewers should be made, particularly in the first days of the survey. If any marked differences are found, a further check should be made to determine whether or not the interview techniques used are the source of the differences.

The interviewer should memorize the questions and develop skill in introducing the questions as part of the general flow of conversation.

The responses are not to be recorded as they are given. Either the interviewer attempts to remember the conversation or he makes very brief, legible notes for use as reference when writing the interview report. In either case, a draft of the interview should be written as soon as possible after the interview and prior to the next interview.

Health workers, working with respondents whom they know well, may be able to use a tape recorder to record the interview. A tape recorder should be used only when both interviewer and respondent feel comfortable talking in its presence. It is better to lose some content then to lose validity due to self-consciousness or structuring of responses because of the presence of a tape recorder. *A tape recorder must never be used without the knowledge and consent of all participants.*

A FEW INTERVIEW TECHNIQUES AND GENERAL POINTS TO REMEMBER

The following hints for conducting a smooth interview session were taken from *Interviewing in Social Research* (Hyman 1954) and represent the combined opinions of thirty-eight different interviewers.

1. Control of the interview
   a. Explain the purpose of the interview to the respondent.
   b. Provide ample time and the appearance of leisure.
   c. The interviewer should control the interview and adapt it to the particular case.
2. Comfort of the respondent
   a. Use an informal manner and tact.
   b. Avoid distractions.
   c. Make the interview agreeable and interesting.
3. Making friendly contact
   a. Opening the interview with the respondent's interests.
   b. Explain the interview to the respondent.
   c. Use the respondent's language or dialect.
   d. Try to establish confidence and some rapport.
   e. Agree with the respondent wherever possible.
   f. Avoid urging frankness on the part of the respondent.
   g. Refer to some common past experience or relate a personal incident similar to one the respondent has related, particularly when the respondent is embarrassed or inhibited.
4. Securing spontaneous responses
   a. Make the interview optional.
   b. Do not grill, coerce, give advice, or show authority.
   c. Avoid antagonizing the respondent.
   d. To secure true responses, avoid leading questions.

The above techniques can be of help in establishing a good interview situation and in encouraging the respondent to participate in the interview. Several additional pointers might be helpful and might have importance for those of us working in a cross-cultural situation.

1. Write only essential information. Write clearly and in a manner that will enable the individual to see what is being written. Place the questionnaire in such a way that the individual can see the form and can see what is being written on it.

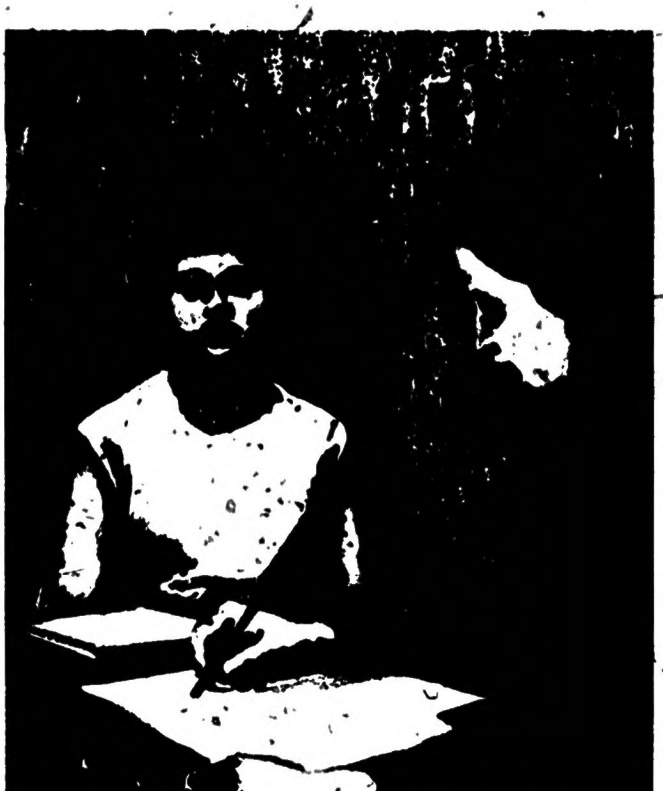
2. Be aware of sensitive areas or sensitive subjects. For example, the subject of death is often a sensitive subject in many Indian communities; therefore, questions asking about recently deceased relatives are not welcome. In other communities persons may not like to be questioned about past illnesses. We should be aware of sensitive subjects and not try to press for information when an individual seems to be uncomfortable discussing them.

3. Avoid showing humor or disbelief. If the individual is expressing religious or medical views which are different from ours we should not laugh or show disbelief toward these views. We should avoid the temptation to teach or "correct" what we might think are "incorrect views." This temptation is often quite strong when we are discussing medical information because we often believe we have "correct" health information and follow "correct" health practices. We feel compelled to give this information to individuals who may have other information or follow other practices. The interview situation is not the place to do this.

4. Be aware of the importance of the "silent language." We should watch our gestures, our dress, and our manner of speaking. Are they in keeping with the customs of the person we are speaking to?

5. Do not be afraid of pauses. Many non-Indian people seem to feel uncomfortable when a lengthy pause occurs in a conversation and feel the need to interject some noise, usually some unnecessary comment. Let pauses occur in the conversation because the individual may be getting his thoughts in order and may be using the pause as an opportunity to think.

6. Listen – *don't interrupt.* This is one of the biggest problems many non-Indians have when talking with Indians. Indian people seldom interrupt each other. Each one says what he has to say and then listens while the other person speaks. If the individual in an interview is straying slightly from the question, do not interrupt him to get back on the track. Wait until he has finished and then rephrase the question in a different manner to guide his conversation to the topic of the question. After a question is asked the individual should be given time to answer. Do not hurry him by providing possible, alternative answers.



When interviewing, place the questionnaire in such a way that the individual can see the form and can see what is being written on it.

Final Reporting and Interpretation

In the purest sense, survey findings are no more than a response to one or more stimuli and not necessarily an accurate reflection of the prevailing conditions and attitudes. The potential user of the information should be provided with a description of the survey objective, organization, methods and techniques used, and questions asked. This will enable him to validate survey findings and determine applicability to his needs.

Provincialism in the interpretation and utilization of survey findings, carries with it the risk of a distorted image of a situation and a one dimensional "solution" to a multi-dimensional problem. The solution arrived at through a narrow approach can inadvertently be contrary to some major policies and objectives of the health programs.

Consider the following example: Random, verbal reports and observations indicated problems with water and sanitation facilities within a community. It was obviously a technical problem and was turned over to the appropriate technicians. A conclusion was reached that the needs could be met by helping the Tribal Government establish a repair and maintenance department. It was also concluded that the workload would require two or more full-time employees, and service charges could make the operation self-sustaining.

A house-to-house survey was required to gather more precise information necessary to implement the plan. Manpower requirements of the survey resulted in the participation of both Tribal Council Members and all Service Unit staff.

The initial technical summary of the field survey results included the following information:

379 homes surveyed in terms of five items (well, pressure or hand pump, kitchen sink, indoor toilet, and septic tank)

609 of the items surveyed, (42%) revealed problems had been encountered at one time or another.

The question, "Willing to pay for services*" elicited an 83% "yes" response.

The above, and similar survey findings, were interpreted as further evidence that a tribal repair and maintenance department was needed, and once established would require little or no subsidy from the Tribal Government.

The involvement of Council and Service Unit staff generated by survey needs for manpower, created an interest on their part that was carried over to an examination of survey findings.

The review by other participants brought about an additional, and in some instances, a different interpretation of the survey findings.

1. "Problems" referred to everything from a faucet drip to a septic tank malfunction. The "609 problems" therefore, provided no cue to the amount and types of maintenance and repair needs, nor the action required to meet these needs.

2. Approximately 80% of the problems reported either were, or could be, corrected by the homeowner.

3. Community residents were predominately in a very low income level. Willingness to pay for repair and maintenance services was not accompanied by the ability to do so.

4. The survey revealed a level of self-sufficiency within the community far beyond anyone's expectations.

5. A tribal operation based upon, and limited to, direct repair and maintenance would discourage existing self-sufficiency and be contrary to both Tribal and IHS policy in this regard.

After all factors were considered, the Tribal Council and health staff agreed, a service organization was needed that emphasized support and extension of home owner self-sufficiency. Direct services, therefore, would be limited to meeting needs requiring special skills and equipment. It was also agreed, in most instances, the direct service cost would be beyond the home owner's ability to pay. The Tribal Government, therefore, should be prepared to provide substantial financial support.

There are several ways to interpret the preceding example. There can be an immediate question of intentional selection of field survey findings to support the conclusions reached prior to the survey. This possibility was ruled out immediately. There had to be a more plausible explanation.

Remember, that the conclusions reached prior to the survey were based only upon observations understandable and meaningful to the observer. In effect, all other available information would be in a "language" foreign to the observer, and therefore incomprehensible. The act of bringing together and tabulating pertinent available information through a formally organized survey does not in itself extend the range of the observer's comprehension. This being the case, there is little reason to expect any significant difference between the conclusions reached through the initial informal observations and those reached through an examination of field survey findings.

The analysis and interpretation of field survey findings by people with different backgrounds introduces a number of viewpoints, and thereby broadens the scope of both the interpretation and conclusions.

In addition to providing factual information, the survey can and should, be utilized as a stimulus to communications and coordination within staff, and between staff and Tribal leaders.

*Verbally described as repair and maintenance.

ANNOTATED BIBLIOGRAPHY

Adams, Richard N. & Jack J. Preiss, **Human Organization Research: Field Relations and Techniques**, The Dorsey Press, Homewood, Illinois, 1960.

This book contains a series of articles grouped under two broad categories, (1) Research Relations, and (2) Field Research Techniques. In the category of Research Relations, the following articles would be of interest to persons working either with health program consultants or with field researchers in rural communities: (a) "Consultants and Clients: A Research Relationship" by S. T. Kimball, M. Pears II, and J. A. Bliss; (b) "The Well-Informed Informant" by K. Bach; (c) "The Validity of Field Data" by Al Vidich and J. Bensman; and (d) "Cross-Class Interviewing: An Analysis of Interaction and Communication Styles" by A. Strauss and L. Schatzman.

The following articles included in the category of Field Research Techniques would be of help to Indian Health Service staff involved in collecting field data: (a) "Categories of Events in Field Observations" by R.H. Guest; (b) "The Collection and Organization of Field Materials: A Research Report" by K. H. Wolff: (c) "Mapping Uses and Methods" by Murray Mebin; (d) "Participant Observation: The Analysis of Qualitative Field Data" by H. S. Becker and B. Geer; (e) "Interviewing in Field Research" by W. F. Whyte; and (f) "Sample Surveys for Social Science in Underdeveloped Areas" by J. M. Stycos.

Bingham, Walter Van Dyke & Bruce Victor Moore, **How to Interview**, Harper & Row, New York, 1959.

The first part of this book, General Principles of the Interview, is most useful to the Indian Health Service staff. This section discusses basic principles of interviewing, the roles of the participants in an interview situation, guideposts to the interview, and the selection and training of interviewers. The remainder of the book deals with specific types of interviews which may be of interest to an IHS reader but would be less useful in our daily work. Some of these types of interview situations include interviewing applicants for employment, oral examining in civil service, public opinion polls, and vocational counseling.

Garrett, Annette, **Interviewing: Its Principles and Methods**, Family Welfare Association of America, New York, 1942.

Although this book was written over twenty years ago, it contains information about interviewing that can be of use to us today. Of particular interest are the chapters dealing with the interviewer's attitude, purpose of interviewing, and how to interview. In the last chapter, Essential Conditions of Good Interviewing, the author gives a number of good hints about the physical setting of the interview, how to record information, the confidential nature of the interview, and the importance of background knowledge on the part of the interviewer.

Hyman, Hubert H., **Interviewing in Social Research**, University of Chicago Press, Chicago, Illinois, 1954.

This book provides a great deal of useful information about the effect of the interviewer on the interview situation. This subject is discussed in some detail and should be of interest to many members of the health service field and clinic staff. The following chapters are particularly useful to persons interested in the effect of the field interviewer on the interview situation and upon the validity of the data collected:

1 A Frame of Reference for the Study of Interviewer Effect.

3. Sources of Effect Deriving from the Interviewer.

6. Interviewer Effect Under Normal Operating Conditions.

7. Reduction and Control of Error.

Much of the information discussed under Interview Techniques in this paper was taken from Chapter 1 of the above book.

Junker, Buford H., **Field Work: An Introduction to the Social Sciences**, University of Chicago Press, Chicago, Illinois, 1960.

Although this book was written primarily for field researchers who are going to be spending a great deal of time living in the communities they wish to study, some of the material presented is useful to the Indian Health Service staff. Of particular interest are Chapter 2 dealing with observing, recording, and reporting of information, and Chapter 3 discussing socially acceptable roles for an observer in a field work situation.

Merton, Robert K., Marjorie Fiske, & Patricia L. Kendall, **The Focused Interview: A Manual of Problems and Procedures**, The Free Press, Glencoe, Illinois.

This book can be extremely useful to members of the Service Unit staff who wish to know more about the responses and reactions of the community to the services of the IHS. A "focused interview" deals with a situation in which the interviewer is asking questions about an event or experience which is familiar to the respondent. For example, an interviewer asking questions about the services of a health center with an individual from a community served by that health center would be an example of a focused interview. The Service Unit staff is often interested in finding out what the residents of a community think about the services provided to that community.

This manual provides many examples and clearly written descriptions of interview situations and problems. Among the topics discussed are questionnaire construction, guides for conducting various types of interviews, hints for guiding or directing the flow of interview conversation, and the use of group interviews.

Oppenheim, A. N. **Questionnaire Design and Attitude Measurement**, Basic Books, Inc., New York, 1966.

Many Service Unit staff members are interested in having more information about the attitudes of the community toward the services provided by the health centers. This book is devoted to attitude measurement and contains much information that can be of use to Service Unit staff. Although most of the chapters contain material that would be useful, four of the chapters discuss topics of particular interest. Chapter 1 concerns the problems of questionnaire design with useful hints on question sequence and types of questions to use in different situations. Chapter 3 discusses question wording, with particular attention to factual questions, leading questions, and questions that might be slightly embarrassing. Chapter 6 concerns attitude statements and includes a discussion on attitudes, beliefs, and values, plus hints on wording questions to bring out attitude statements. Chapter 9 contains some very useful information about the quantification of questionnaire data, particularly the coding of questions, punch card layout, and the analysis of questionnaire data. This book is very clearly written and should be helpful to anyone involved in an attitude study.

Richard, Stephen A., Barbara Snell Dohrenwend, & David Klein, **Interviewing: Its Forms and Functions**, Basic Books, Inc. New York, 1965.

The third and fourth part of this book are the most useful for individuals interviewing in the Service Unit. Part III, the Question-Answer Process, offers helpful information about the criteria of good responses, expectations of interviewers and their effect on an interview, the effect of leading questions, and the content of questions. Part IV, Interviewer and Respondent, discusses characteristics of interviewers and respondents and the interviewer-respondent relationship.

The appendix of this book offers an interesting study of personality characteristics of social science field workers by S. A. Richardson.

Other Articles of Interest

The following articles are all from the journal **Human Organization** and concern various aspects of field research. **Human Organization** is published by the Society for Applied Anthropology and contains a section devoted to Techniques of Field Research. Many of the articles appearing in this section would be of interest to Service Unit staff members who are gathering information or working with persons gathering information from community residents.

Adair, John, "The Indian Health Worker in the Cornell-Navajo Project," **Human Organization**, 19:59-63, 1960.

Babchuk, Nicholas, "The Role of the Researcher as Participant Observer and Participant-as-Observer in the Field Situation," **Human Organization** 21:225-228, 1962.

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Dohrenwend, Barbara Snell and Stephen A. Richardson, "A Use for Leading Questions in Research Interviewing," **Human Organization**, 23:76-77, 1964.

Friedson, Eliot, "Specialties Without Roots: The Utilization of New Services," **Human Organization**, 18: 112-116, 1959.

French, Kathrine S., "Research Interviewers in a Medical Setting: Roles and Social Systems," **Human Organization**, 21:225-228, 1962.

Messing, Simon D., "The Application of Health Questionnaires," **Human Organization**, 24:365, 1965.

Pelz, Donald C., "The Influence of Anonymity on Expressed Attitudes," **Human Organization**, 18:88-91, 1959.

Richardson, Stephen A., "The Use of Leading Questions in Non-Schedule Interviews," **Human Organization**, 19:86-89, 1960.

Roemer, Milton I., "Social Science and Organized Health Services," **Human Organization**, 18:75-77, 1959.

Wolf, Eleanor P., "Some Questions about Community Self-Surveys: When Amateurs Conduct Research," **Human Organization**, 23:85-89, 1964.

GPO 858-466