THE DEVELOPMENT OF A POST-SECONDARY PROGRAM IN HEALTH PROMOTION FOR NATIVE PEOPLES

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by

Pamela E. MacAskill

A practicum presented to the University of Manitoba in partial fulfillment of the requirements for the degree of Master of Education in the Faculty of Education.

Winnipeg, Manitoba
1986

ISBN 0-315-37371-7

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This work is dedicated to
Mr. J.B. Whitcombe and
Miss S. Muir whose light
has sustained many a weary
traveller such as myself.

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Present Conditions

Introduction

On December 13, 1979, the federal government issued a document entitled the New Indian Health Policy (Health and Welfare Canada [HWC], 1979). This replaced the previous Indian Health Policy issued in November, 1974. What made this policy statement new was its recognition of the need for an active role for native peoples in their own health care and communal well-being. The New Indian Health Policy states:

> The over-riding fact from which the policy stems is the intolerably low level of health of many people, who exist under conditions rooted in poverty and community decline. The Federal Government realizes that only Indian communities themselves can change these root causes and that to do so will require the wholehearted support of the larger Canadian community. Hence, the goal of the Federal Indian Health Policy is to achieve an increasing level of health in Indian communities, generated and maintained by the Indian communities themselves (HWC, 1979, p.1).

This policy statement marked the first step towards the devolution of health care services from the federal government to the Indian bands. While very general in scope, this document hints both at the complexity of the devolution process and at the enormity of the problem of native health care. It alludes to the need for an interrelated systemic approach to the delivery of Indian health care in its "three pillars" concept.

The three pillars of the New Indian Health Policy are:

> Pillar 1 - Community Development
> Pillar 2 - Communications and Involvement
> Pillar 3 - Interrelated Health Services
> (HWC, 1979, p.2)

According to the policy statement, community development is the first pillar because "both socio-economic development and cultural and spiritual development, [are necessary] to remove the conditions of poverty and apathy which prevent the members of the community from achieving a state of physical, mental, and social well-being (HWC, 1979, p. 2)." This wholistic approach touches on issues related to the impossibility of effecting significant change using isolationist strategies. The World Health Organization (WHO) supports this view and recognizes the "inextricable link between people and their environment (WHO, 1984, p. 2)."

The second pillar of the New Indian Health Policy acknowledges the traditional relationship between Canadian Indians and the federal government as set forth in Section 91 of the Constitution Acts, 1867 and 1981. Pillar 2 establishes the federal government in an advocacy role on behalf of Indians. In this role, the federal government is to act as an "advocate of the interests of Indian communities to the larger Canadian society and its institutions, and promotes the capacity of Indian communities to achieve their aspirations (HWC, 1979, p. 2)." The policy statement further notes that the relationship between Canada and her native peoples "must be strengthened by opening up communication with the Indian people and by

encouraging their greater involvement in the planning, budgeting and delivery of health programs (HWC, 1979, p. 2)."

Pillar 3 delineates the elements of the Canadian health system and notes the jurisdictional areas of responsibility of the federal government, the provincial governments, and the private sector. The role of significance for Indian bands as outlined in the third pillar of the New Indian Health Policy is in the area of health promotion. The document states:

> Indian communities have a significant role to play in health promotion, and in the adaptation of Health Services delivery to the specific needs of their community. ...[The Federal Government] is committed to promoting the capacity of Indian Communities to play an active, more positive role in the health system and in the decisions affecting their health (HWC, 1979, p. 2).

Just what strategies will be employed by the federal government to enable Indians to assume the role outlined for them in their 1979 policy is still unresolved. The establishment of the Indian and Inuit Health Careers Program by Medical Services Branch (MSB) of Health and Welfare Canada (HWC) in 1983 testifies to the fact that there is a dearth of health professionals of Indian ancestry available to effect the changes required by devolution and to act as role models to Indian youth.

It is the intent of this practicum to develop a baccalaureate-level model for educating native peoples in the area of health promotion. Further, it is the intent of this practicum to demonstrate the consonance of the health promotion philosophy as

outlined by the WHO Regional Office for Europe with Indian cultural beliefs and values. For the purposes of this practicum, the words "Indian" and "native" are synonymous and refer to persons of Indian ancestry living primarily, but not exclusively, on reserves. Also, for the purposes of this practicum, the concept of health is viewed as a social construct incorporating a broad spectrum of values, behavioural elements, economic interests, environmental factors, and cultural concerns (Kickbusch, 1981). The term, health promotion, "represents a mediating strategy between people and their environments, synthesising personal choice and social responsibility in health to create a healthier future (WHO, 1984, p. 2)." This definition of health promotion is that espoused by the WHO, of which Canada is a member state. In its literature, the WHO describes health promotion as follows:

> Health promotion is the process of enabling people to increase control over, and to improve, their health. This perspective is derived from a conception of "health" as the extent to which an individual or group is able, on the one hand, to realise aspirations and satisfy needs; and, on the other hand, to change or cope with the environment. Health is, therefore, seen as a resource for everyday life, not the objective of living; it is a positive concept emphasising social and personal resources, as well as physical capacities (WHO, 1984, p. 3).

To place this practicum in perspective, it is necessary to begin by examining the current state of health and education in Indian communities. National data are included as well as information related specifically to Manitoba. However, interviews with health professionals in Ottawa indicate many commonalities between regional and national concerns as they relate to Indian health and education.

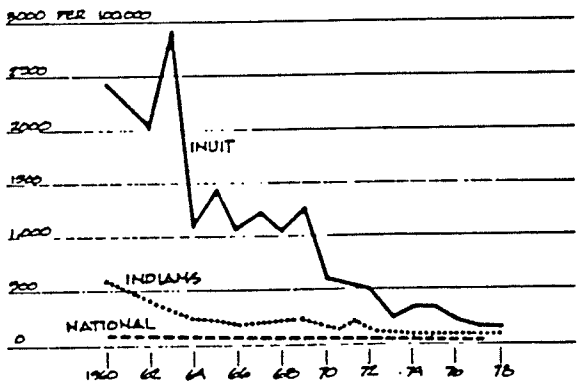
Health

Medical Services Branch (MSB) of Health and Welfare Canada (HWC) has as part of its mandate the provision of health care services to the Indian and Inuit peoples of Canada. As stated in the 1982/83 Annual Review, this part of the MSB mandate empowers the federal government "to pursue actively a program of assitance to Indians, Inuit and residents of the Yukon and the Northwest Territories, so that they have access to health services and attain a standard of health comparable to that of other Canadians; in addition, to increase levels of quality and effectiveness in the delivery of such programs while exercising fiscal responsibility (HWC, 1983, p. 1)." In fulfilling the terms of this part of its mandate MSB provides health services to the 323,000 Registered Indians and 25,000 Inuit of Canada.

That MSB has been successful in achieving some of the objectives arising from its mandate is well documented. Health indicators related to tuberculosis, diseases of the respiratory system, neonatal deaths, and infections and parasitic diseases show a sharp decline over the past twenty years. (See figures 1.1, 1.2, 1.3, and 1.4 for illustrative comparisons.) Communicable diseases and illnesses related to other ailments are also less prevalent. MSB notes:

> Communicable diseases which were once rampant among the Indian and Inuit populations are now present at levels close to the national rates. Many forms of ailments and accidents which once would typically prove fatal or severely debilitating, are now less traumatic; adequate medical care in many communities has reduced the risks of the more severe outcomes and complications of morbidity (HWC, 1985, Appendix 1, p. 3).

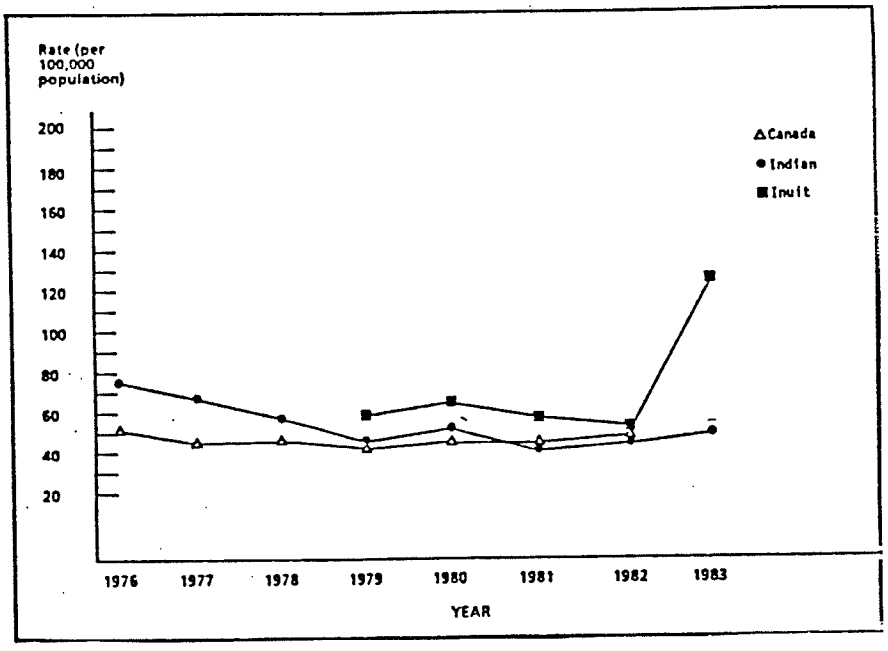
FIGURE 1.1: Tuberculosis (New and Reactivated Cases) per 100,000 population



sources:
(1) "Tuberculosis Statistics Review – 1977" unpublished report by Medical Services Branch, Health and Welfare Canada
(2) *Annual Report 1978: Medical Services Branch*, Health and Welfare Canada

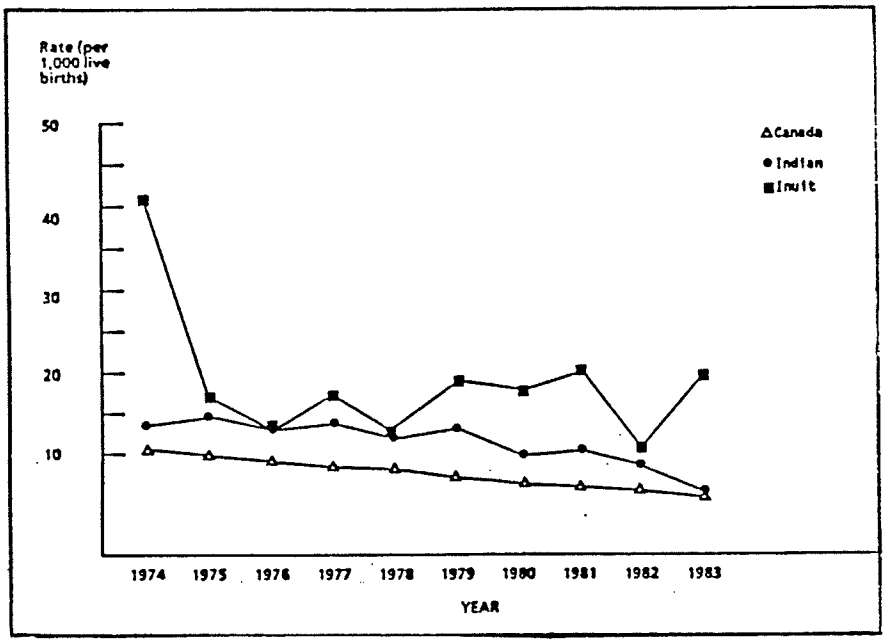
SOURCE: Support for Indian and Inuit Health Promotion: A Primary Prevention Initiative by Health and Welfare Canada, 1985, Appendix 1, p. 3.

FIGURE 1.2: Deaths from Diseases of the Respiratory System



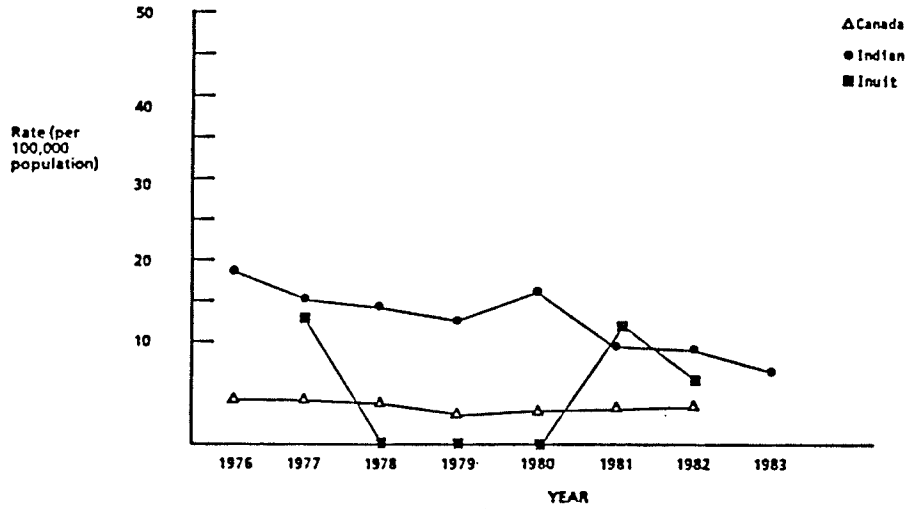
SOURCE: Support for Indian and Inuit Health Promotion: A Primary Prevention Initiative by Health and Welfare Canada, 1985, Appendix1, p. 4.

FIGURE 1.3: Neonatal Deaths
(First 28 Days after live Birth)
per 1,000 Live Births



SOURCE: Support for Indian and Inuit Health Promotion: A Primary Prevention Initiative by Health and Welfare Canada, 1985, Appendix 1, p. 5.

FIGURE 1.4: Deaths from Infections and Parasitic Diseases
per 100,000 Population



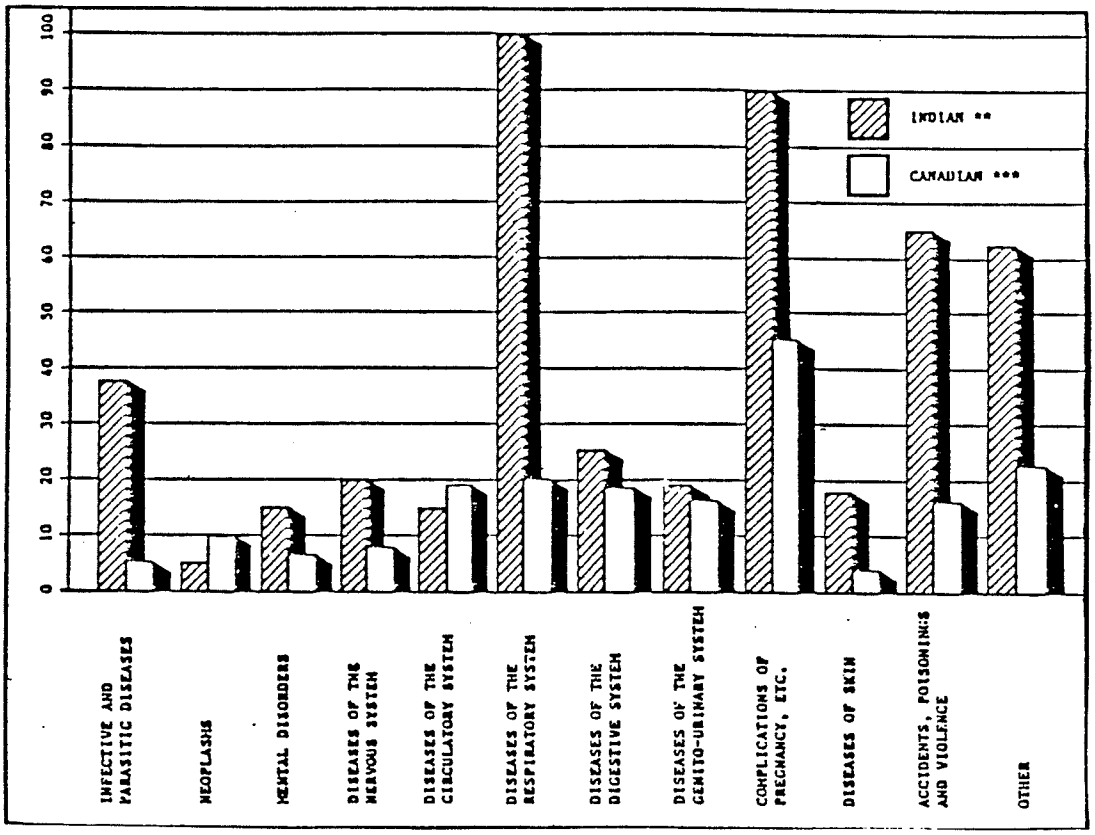
SOURCE: Support for Indian and Inuit Health Promotion: A Primary Prevention Initiative by Health and Welfare Canada, 1985, Appendix 1, p. 6.

The most interesting feature of figures 1.1, 1.2, 1.3, and 1.4 is that, compared to trends evidenced in the general Canadian population, Indian and Inuit peoples still exhibit incidences of disease higher than the Canadian average. This suggests causes of distress and disease which are not alleviated by standard medical intervention strategies.

The strategies MSB has employed in providing health services to Indian and Inuit and in achieving the results noted above involve mainly secondary and tertiary care. "Indian and Northern Health Services operate some 468 facilities ranging from outpost nursing stations to fully-equipped hospitals (HWC, 1983, p. 3)." More recently Health and Welfare Canada has become involved through MSB in supporting the National Native Alcohol and Drug Abuse Program (NNADAP) and access programs designed to train Indians and Inuit in the health professions.

However, despite the strides that have been made, the situation is still desparate. As figure 1.5 shows, except for cancer and diseases of the circulatory system, Indians have a higher rate of hospitalization for disease than other Canadians. They also have higher suicide rates among young people than the national average as well as higher incidences of death from injury, poisoning, and fire. (See figures 1.6, 1.7, and 1.8.)

FIGURE 1.5: Hospital Segregation per 1,000 Population
Registered Indians in British Columbia, Saskatchewan
and "on-reserve" in Alberta, and Canada
by Disease Categories, 1977 (Canada 1976)



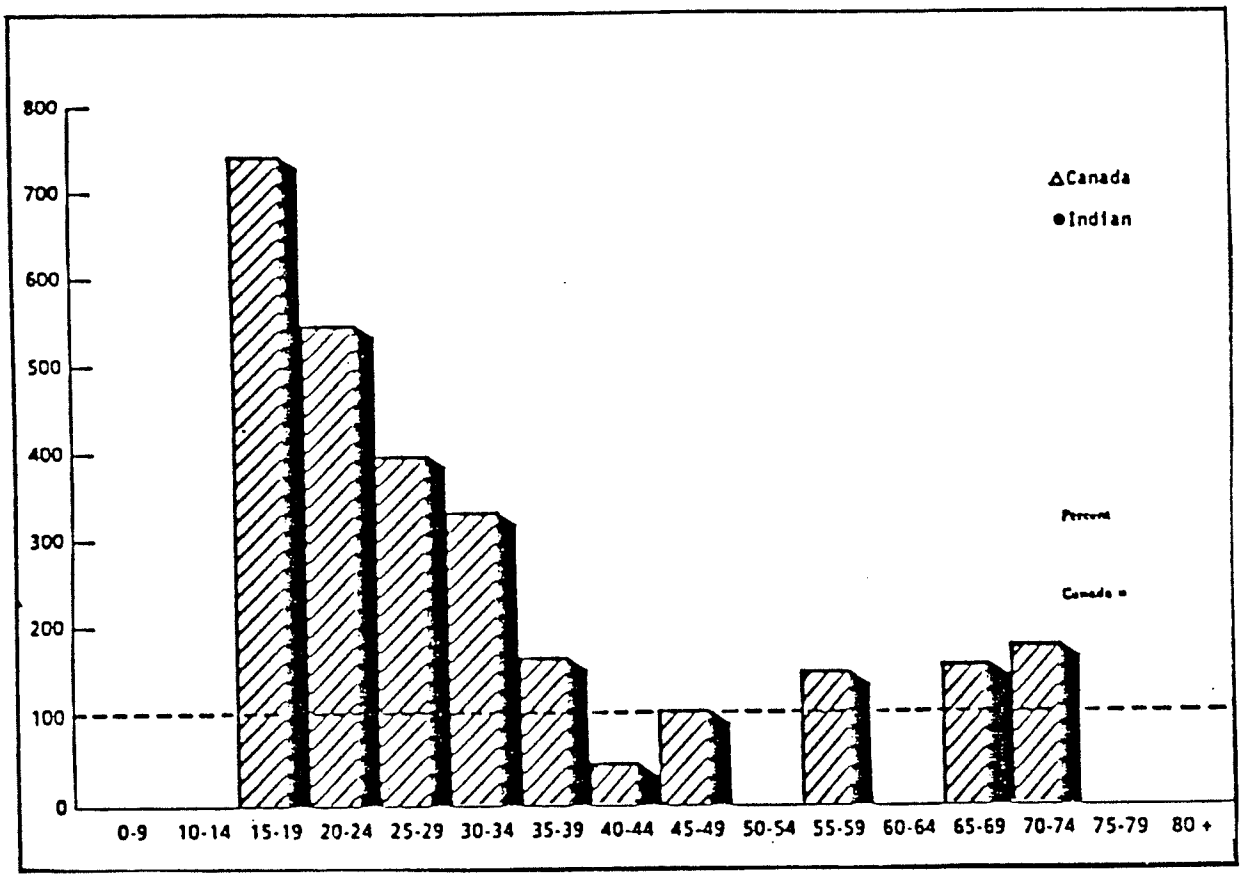
* Source: Hospital Morbidity, Catalogue 82-206; unpublished data, Health Division, Statistics Canada

** Rates for the Indian population are based on 1977 hospital data for registered Indian populations for Saskatchewan and British Columbia and persons residing on-reserves in Alberta

***Rates for the Canadian population are based on 1976 hospital data with the exception of Prince Edward Island 1977 figures and New Brunswick 1975 figures

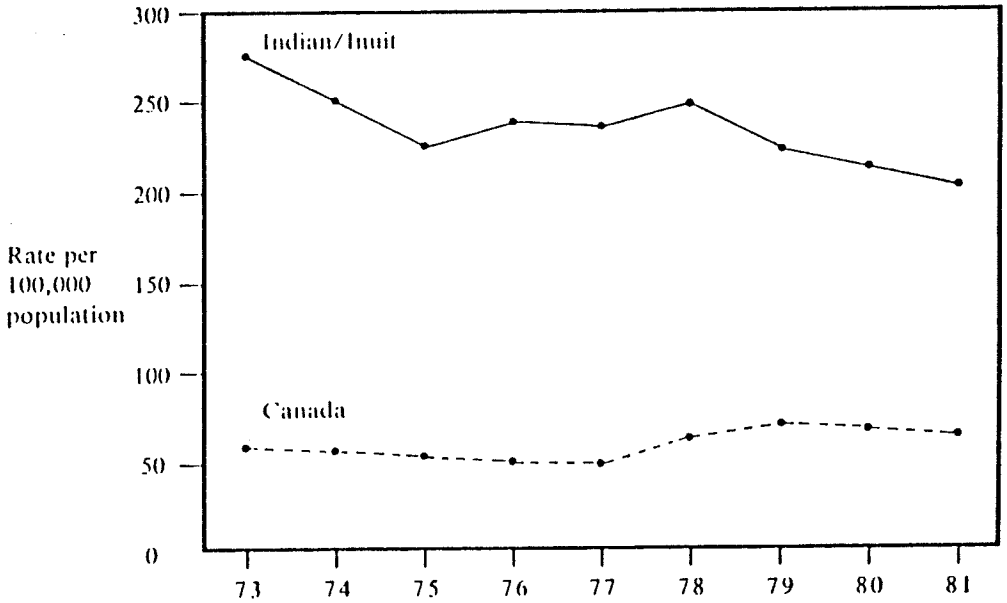
SOURCE: Support for Indian and Inuit Health Promotion: A Primary Prevention Initiative by Health and Welfare Canada, 1985, Appendix 1, p. 17.

FIGURE 1.6: Age Specific Suicide Rate - Indian Population as Percentage of Canadian Population 1982



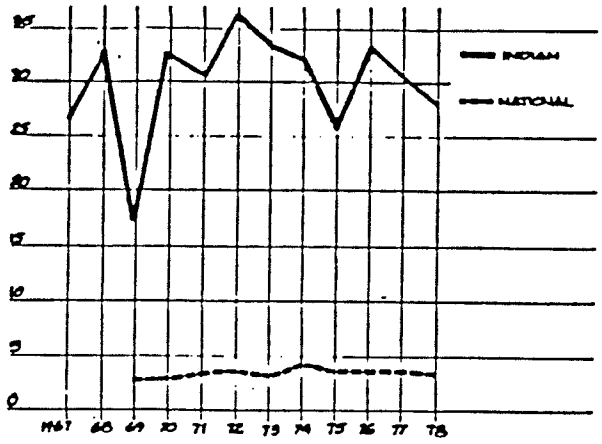
SOURCE: Support for Indian and Inuit Health Promotion: A Primary Prevention Initiative by Health and Welfare Canada, 1985, Appendix 1, p. 14.

FIGURE 1.7: Indian Deaths from Injury and Poisoning



SOURCE: Annual Review 1982/83 by Health and Welfare Canada, 1983, p. 18.

FIGURE 1.8: Fire Deaths (per 100,000 Population)



SOURCE: Support for Indian and Inuit Health Promotion: A Primary Prevention Initiative by Health and Welfare Canada, 1985, Appendix 1, p. 16.

As the previous figures illustrate ill-health among native communities is not expressed solely in diseases of the body although these are significant. MSB illustrates this latter point well and concludes:

> The incidence of many illnesses and disorders is higher among the Indian population than among the Canadian population as a whole. Of the principal causes of hospitalization ..., only neoplasms (cancers) and diseases of the circulatory system indicate lower levels of hospitalization for the Indian population than for the Canadian population as a whole.
>
> The three leading causes of hospitalization among the Indian population, in descending order, are: diseases of the respiratory system (approximately 5 times the national rate); complications of pregnancy (approximately double the national rate) and accidents, poisonings and violence (approximately 3 1/2 times the national rate). To a large extent, the higher levels of morbidity are a reflection of hazardous lifestyles and adverse environmental conditions (HWC, 1985, Appendix 1, p. 18).

The picture painted by these statistics and by the illustrations in figures 1.6, 1.7, and 1.8 is a dismal one and can lead to speculation that the reason Indians have lower incidences of neoplasms and diseases of the circulatory system is that they don't live long enough to develop cancer or to have heart attacks. There is some support for this speculation. "In 1981, Indian males were expected to live an average of 9.5 years fewer than the national male population, while Indian women were expected to live an average of 10.0 years fewer than the national female population (HWC, 1985, Appendix 1, p. 8)." MSB notes:

> In general, health improvements have been most significant in areas where conventional secondary prevention and treatment approaches have been most

> amenable. The continuing and worsening health problems among Indians and Inuit tend most often to be in areas where conventional approaches are not particularly effective. Most specifically, they tend to be in areas more directly connected to mental health, lifestyles, and social, economic and physical environment conditions (HWC, 1985, p. 14).

That lifestyles and environmental factors play a major role in the illness and mortality of native peoples is reiterated in the Indian Mental Health Research Formulation authored by the First Nations Confederacy (FNC), the Brotherhood of Indian Nations, and Manitoba Keewatinowi Okimakanak in August, 1985. This study surveyed 57 Manitoba Indian communities. Data gathered indicate that the following factors are regarded by Indians as environmental stresses contributing to poor individual and community health:

-educational problems	98.2%
-socio-economic status	91.2%
-lack of recreation	77.2%
-internal resource person problems	73.7%
-lack of native cultural awareness	63.2%
-family break-up	61.4%
-government funding deficiencies	61.4%
-transportation difficulties	47.4%
-overcrowding	45.6%
-lack of elders influence	36.8%
-poor housing quality	36.8%
-lack of adequate water/sewage/sanitation	36.8%
-crime concerns	29.8%
-lack of effective communications system	29.8%
-environmental problems	28.8%
-law enforcement deficiency	21.0%
-nutritional concerns	19.3%
-high turnover of outside personnel	7.0%

(FNC et al, 1985, p. 23).

Of the twelve health problems rated by participants in the Indian mental health study, depression and anxiety match alcohol abuse and violence in consistently being rated as a major problem,

threatening the stability of the community. (See Appendix 1 for a complete breakdown of ratings.) The descriptors related to depression note that the "majority of depressive symptoms were referred to feelings of hopelessness about the future both of their selves and families and of their communities. A feeling of being overwhelmed by events (FNC et al, 1985, p. 33)." As for anxiety, "the degree of 'nervousness' was reported on, often in the context of worrying about the future, about the children, about the general problems of the community (FNC et al, 1985, p. 33)."

Concern about future prospects and a sense of helplessness and hopelessness are characteristic of states of dependency (Bryde, 1970). In part, the systems put in place to aid native peoples have fostered dependency on external systems and institutions rather than built capacities within Indian communities (Sealey, 1980). At this point in time, and perhaps encouraged by the growing militancy and political acumen of Indians, Health and Welfare Canada has adopted the health promotion philosophy advocated by the WHO. The adoption of this philosophy by Health and Welfare Canada and particularly by MSB demonstrates recognition of the fact that many of the social ills and physical illnesses which plague native peoples are not amenable to standard, medical-model treatment approaches. Many of the "most serious health problems facing Indians...require addressing of underlying root causes and shaping of values, lifestyles, and environments (HWC, 1985, Appendix 1, p. 6)."

Education

Like health care, education for Registered Indians falls under the purview of the federal government. Recent Developments in Native Education notes:

> The federal government's responsibility towards Indians has its constitutional basis in Section 91 of the British North America Act, which assigns exclusive authority to the Parliament of Canada to legislate with respect to Indians and lands received for Indians. The Indian Act, in Section 114 to 123 inclusive, empowers the Minister of Indian Affairs and Northern Development to operate schools and also to enter into agreements with provincial governments, territorial commissioners, school boards and religious and charitable organizations for the education of registered Indian children from the ages of 6 to 17 inclusive, living on reserves or Crown lands. ...
>
> The federal government also assumes reponsibility for the education of Inuit children in littoral Quebec and in other provinces where there is an Inuit population. Federal schools exist in every province except Newfoundland (Canadian Education Association [CEA], 1984, p. 11).

[In a recent reorganization the federal government changed the name of the Department of Indian Affairs and Northern Development (DIAND) to Indian and Northern Affairs Canada (INAC). For the sake of continuity, the term INAC will be used in this text except in direct quotes.]

Indian and Northern Affairs Canada (INAC) is responsible for providing educational services to Indian communities. This federal department was established under Section 15 of the Government Organization Act in 1966. The policies of INAC have changed considerably since the first Indian Affairs Branch was established in 1873. Present policy reflects INAC's agreement with the

principles of local control of Indian education as articulated in the National Indian Brotherhood's 1973 report, Indian Control of Indian Education. The current objectives of INAC are:

1) to assist and support Indian and Inuit people in having access to educational programs and services which are responsive to their needs and aspirations, consistent with the concept of Indian control of Indian education.
2) to assist and support Indian people in preserving, developing and expressing their cultural identity with emphasis upon their native languages.
3) to assist and support Indians and Inuit in developing and/or having access to meaningful occupational opportunities consistent with their community and individual needs and aspirations (CEA, 1984, p. 13).

While these objectives are laudable, their translation into practice has been difficult and uneven. Partly, the difficulty stems from a lack of agreement on what constitutes "local control" as well as a lack of guiding principles and operating guidelines. The situation as described by the Canadian Education Association (CEA) captures the essence of the problem:

> The concept of local control enables bands to decide whether or not they want to operate their own schools and to set the pace at which such change should occur....
>
> The lack of a systematic framework for transferring control to Indian bands has been the major obstacle to the success of band schools. As well, misunderstandings over the scope of local control persist. The original intent of the concept was that Indians should have an influence on education similar to that of other Canadians over the education of their children. This perspective has largely been lost and many groups tend to feel that local control is a delegation of responsibility to allow bands to do as they see fit. The responsibility for funding and for assuring that Indian children receive a proper education has always remained firmly with the DIAND. Thus, before agreeing to local control, the DIAND assures itself that the band will follow a number of guidelines and

> conditions. Unfortunately, during the early years of local control implementation, the bands were not adequately prepared to assume control of their education and the government offered them little assistance. In some cases, frustration and disagreements over funding prompted bands to return their schools to the DIAND. Even now the transfer of schools is hampered by the lack of a proper framework, guidelines and criteria to let both parties know exactly what is expected of them and what steps to follow (CEA, 1984, p. 77).

It is a testament to the commitment of both the federal government and Indian bands to the concepts of local control and cultural relevance in the classroom that so many band operated schools now exist. (See figure 1.9.)

FIGURE 1.9: Breakdown by Province of Federal and Band Operated Schools (June 1983)

Province	**Federal**	**Band**
Newfoundland	-	-
Prince Edward Island	1	-
Nova Scotia	3	2
New Brunswick	4	3
Quebec	13	8
Ontario	63	14
Manitoba	18	31
Saskatchewan	31	32
Alberta	18	10
British Columbia	19	87
Total	170	187

SOURCE: Recent Developments in Native Education by Canadian Education Association, 1984, p. 78.

The push for local control of education by native leaders arises from a long history of dissatisfaction with the nature and

quality of education available to Indians. Contentions that the education system established for Indians has undermined their social systems, disrupted family relationships, robbed them of their cultural identity and self-esteem, and ill-prepared them to cope with the dominant, increasingly technical, society are abundant and well-documented (Barman et al., 1986; Persson, 1986; Sealy, 1980). The Assembly of Manitoba Chiefs (AMC) 1984 report on Indian education paints a dismal picture of the effectiveness of conventional educational programming. Data on Indian students indicate that:

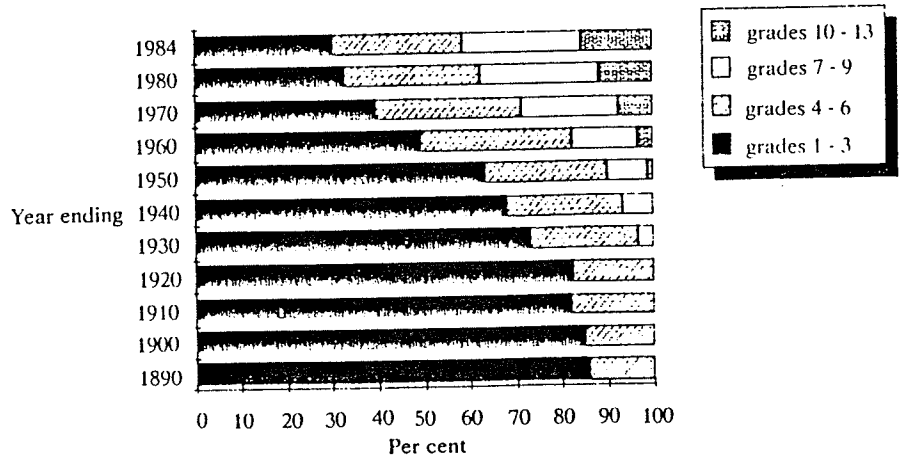
1) only 2% who start in grade 1 complete grade 12;
2) one-third of those of school age are not enrolled in school;
3) Indian pupils on average fall several grade levels behind pupils enrolled in provincial schools after elementary education;
4) English, the required language of instruction, is a foreign language to over 90% of northern Indians;
5) a disproportionate number of Indian pupils in provincial schools are placed in special or slow learner classes without the approval of parents (AMC, 1984, p. 1).

The AMC report indicts INAC for providing curricula weak in the areas of science, language arts, mathematics, and vocational training and for underfunding education on reserves. A 1979/80 comparison of costs per pupil in various school systems reveals that provincial schools received a fee of $3,082. per pupil,

local-operated schools $2,810., and federal-administered schools $1,748. "And so, in spite of a near doubling of its education budget over the past half-decade, the Manitoba Region, Department of Indian Affairs and Northern Development is still playing 'catch up' in an apparently losing game to attain the standards of education available in provincial schools (AMC, 1984, p. 3)."

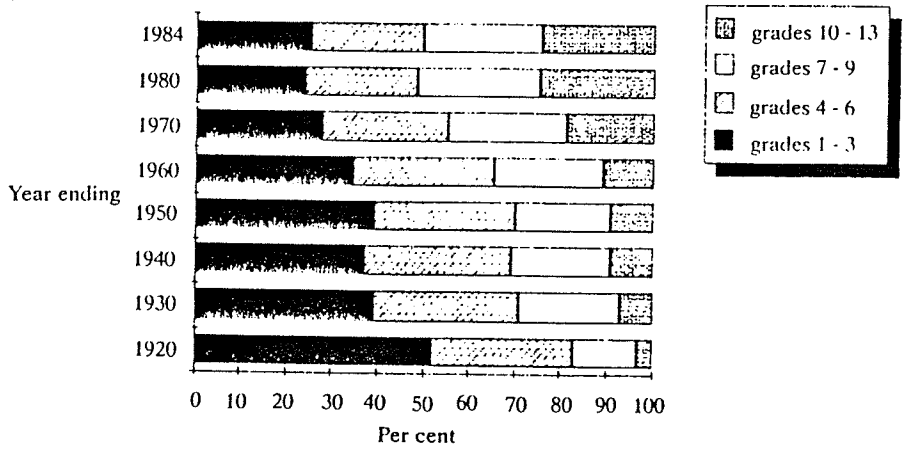
The AMC's concerns become painfully obvious when the educational attainment of Indians is compared to that of other Canadians. A comparison of Figures 1.10 and 1.11 reveals a sharp decline in the participation of Indian students at the secondary school level. Statistics gathered from Manitoba sources support the national picture and identify a 50% drop-out rate for each grade from grade 7 onwards (AMC, 1984; Lee, 1983).

FIGURE 1.10: Grade Distribution of Indian Children in School in Canada, 1890-1984



SOURCE: Indian Education in Canada, Volume 1: The Legacy by J. Barman, Y. Hebert, and D. McCaskill (Eds.), 1986, p. 18.

FIGURE 1.11: Grade Distribution of Children in Provincial Schools in Cananda, 1920 - 1984



SOURCE: Indian Education in Canada, Volume 1: The Legacy by J. Barman, Y. Hebert, and D. McCaskill (Eds.), 1986, p. 18.

Reasons given for this drop-out phenomenon are usually cultural. Bryde (1970) in his work on the scholastic performance of Sioux children found that the children start kindergarten with scores on standardized tests six months to a year and a half behind their non-native peers. However, by grade 3, the Sioux children are acclimatized to the school environment and attain or exceed standardized norms during grades 4 to 6. This "golden age of achievement", as Bryde calls it, begins to decline in grade 7 and this decline continues on through to grade 12. Indications from Bryde's research are that the disparity between the cultural values of the Sioux as expressed in the home and the values of the dominant society as expressed in the school become so great during adolescence that the child succumbs to this stress and retreats.

This view is supported by specialists in cross-cultural education. Sealey (1980) points out:

> Within many Native communities the way of life is so at variance with that of the dominant society that little reinforcement is given the work of the school. Parental roles, community routines, language, values, communication patterns, the limited academic background of many parents and, until recently, the absence of the usual influences exerted by mass media, all contribute to discontinuity between the home and the school (p. 56).

The significance of culture to education cannot be dismissed. Many curriculum theorists contend that knowledge of the meaning and impact of culture and social values are central to the process of curriculum development and educational relevance (Taba, 1962; Tanner and Tanner, 1980). "Since education is always an expression of a civilization and of a political and economic system, schools must harmonize with the lives and ideas of people in a particular time and place (Hass, 1983, p. 42)." It is just this harmony that Indians are seeking in education. Historically, cultural interaction between natives and non-natives "has been characterized by co-operation and conflict but, more importantly, by misconceptions and contradictions. ... Aboriginal cultures were dismissed as irrelevant, while in reality they were vital and coherent, so much so that they have survived centuries of European domination (Barman et al., 1986, p. 2)." Today, Indian people are striving through local control of education and through other avenues of self-determination and devolution to re-assert their ancestral dignity and to find a place of balance and harmony for themselves within Canadian society.

The Desire for Change

The foregoing sections give evidence of the failure of the systems developed by INAC and MSB. Increasingly native peoples are calling for self-determination and the right to develop educational, health care, and other systems which are compatible with native lifestyles and culture. As the Manitoba Indian Mental Health Research Formulation so emphatically states: "there will never be adequate mental health programs (or economic or other programs) until the majority of the resource people are trained members of the community. The non-Indian resource people should be available with their expertise as needed but not as the prime movers (FNC et al., 1985, p. 12)." This sentiment is reiterated by the Assembly of Manitoba Chiefs (1984) which points to increased student attendance and retention rates as evidence of the value of Indian participation in education. Goodwill (1984), in a survey of the members of the Indian and Inuit Nurses Association, documents a similar viewpoint. She notes:

> 99% of the respondents were convinced that Indian and Inuit health services should be delivered by Indian and Inuit people, based on their knowledge and understanding of the culture, language, customs, and perceptions of their people, which would facilitate the transfer of local control of health services and programs (Goodwill, 1984, p. 10).

That the federal government agrees in principle with the views of native peoples on local control and self-determination is evident

in recent policy statements. However, the processes by means of which local control is implemented are ill-defined. In education, progress towards local control continues. Today 450 of the 573 Indian bands in Canada have assumed some degree of administrative control of reserve schools (CEA, 1984). In addition, three school boards - the Nishga in British Columbia and the Cree and Kativik in Quebec - have become Indian controlled (Barman et al., 1986; CEA, 1984). Unfortunately, the legal and financial aspects of the devolution of education from INAC to local bands have yet to be resolved. Indian Education in Canada, Volume 1: The Legacy describes the sitation as follows:

> While control over education remains at the heart of self-determination, actual transfer of control has been hindered by the lack of a direct legal basis for transfer in the agreement reached in 1973 between the federal government and the National Indian Brotherhood. Despite repeated Indian initiatives, the federal government has been unwilling to resolve the impasse, as acknowledged in a 1982 position paper, that "the failure to establish guiding principles and develop operational guidelines has impeded the development of Indian education and restricted implementation of the Department's policy".
>
> The principal area of contention centres on control over finance and thereby on the boundaries of Indian decision-making authority (Barman et al., 1986, p. 16).

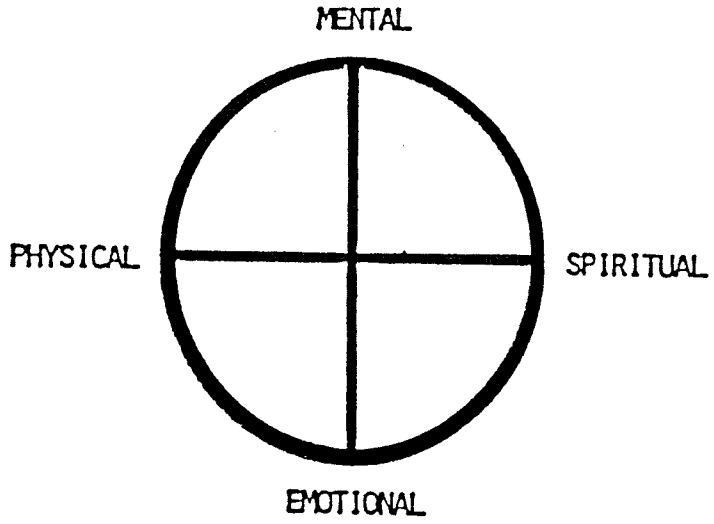
While some may contend that wrangling over money is base when dealing with an issue as central as education, this is an idealistic attitude. "A nasty but indisputable fact of life is that the only true freedom is economic independence (Sealey, 1980, p. 72)."

To assume that the devolution of health care services from MSB to Indian bands will proceed more smoothly than the devolution of

education is naive given the nature of government and bureacratic systems. However, Indian leaders appear to be as determined to undertake this area of devolution as they were to undertake local control of education. The hardship entailed can be no greater than that of living with attitudes and systems which are inimical to Indian values and beliefs about health and the purpose of human life. "Whatever their ecological base and specific lifestyle, Canada's aboriginal peoples shared certain cultural attributes, including a belief in the unity of all aspects of life and consequent lack of distinction between the 'secular' and the 'sacred' (Barman et al., 1986, p. 3)." This belief has found renewed expression in the revitalization of native symbols, such as the "medicine wheel", as metaphors to conceptualize the Indian attitude towards health. The MSB document entitled Support for Indian and Inuit Health Promotion: A Primary Prevention Initiative (1985) notes the significance of this metaphor and states:

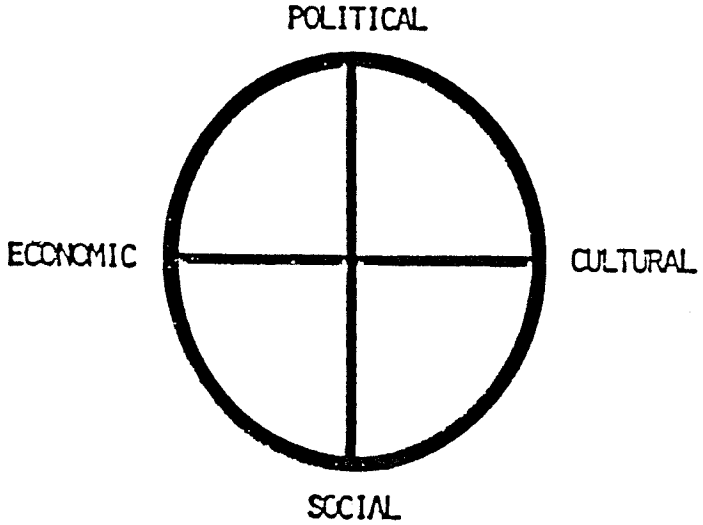
> As with indigenous populations in other cultures, Indians and Inuit have long recognized the complexity of factors and forces affecting health. For example, in some tribes, a medicine wheel depicted the interrelationships of spiritual, physical, social and biological elements of the total environment; how they give meaning to the concept of health; and how they affect health. The medicine wheel emphasizes wholeness and balance. Recent depictions of the medicine wheel in such cultural settings emphasize the importance of the total environment on individual and community health. Figures [1.12 and 1.13] depict medicine wheels emphasizing concepts of health expressed in terms of <u>individual</u> potentiality and <u>collective</u> potentiality (HWC, 1985, Appendix 2, p. 31).

FIGURE 1.12: Medicine Wheel: Health as Individual Potentiality



SOURCE: Support for Indian and Inuit Health Promotion: A Primary Prevention Initiative by Health and Welfare Canada, 1985, Appendix 1, p. 32.

FIGURE 1.13: Medicine Wheel: Health as Collective Potentiality



SOURCE: Support for Indian and Inuit Health Promotion: A Primary Prevention Initiative by Health and Welfare Canada, 1985, Appendix 1, p. 32.

Philosophically this wholistic view underpins the GREAT LEARNING ENTERPRISE initiated by native elders at a conference on alcohol and drug abuse held at the University of Lethbridge in 1982. Emerging from this conference was the articulation of four key strategic principles which recognize "the essential capacity of human beings to develop; to individually and collectively re-create themselves in a new image (Bopp and Bopp, 1984, p. 106)." These four principles are:

1) the heart of the problem lies within the native communities and the solution must come from these same communities;
2) the future is inseparably linked to the past and problems must be viewed in their cultural and historic context;
3) "in order for native people to become competent directors of their own healing and development process ..., able to anticipate and respond creatively to hitherto unimagined futures, a GREAT LEARNING ENTERPRISE IS REQUIRED. This learning enterprise would have to systematically educate human beings from the time they are in their mother's womb until the time they pass out of this world (Bopp and Bopp, 1984, p. 106).";
4) the well-being of the individual is linked to the health of the individual's social and cultural life-context.

This philosophical orientation is consistent with the health promotion concept and philosophy articulated by the WHO Regional

Office for Europe and adopted by MSB. To reiterate, this approach states: "Health promotion represents a mediating strategy between people and their environments, synthesising personal choice and social responsibility in health to create a healthier future (WHO, 1984, p. 2)." The five principles of health promotion developed by the WHO (1984) are congruent with the four key principles articulated by native elders (Bopp and Bopp, 1984) in that they are wholistic and stress integration, context, and cooperation. The five principles of health promotion are:

1) health promotion involves the population as a whole in the context of their everday life, rather than focusing on people at risk for specific diseases;
2) health promotion is directed towards action on the determinants or causes of health. Health promotion, therefore, requires a close cooperation of sectors beyond health services, reflecting the diversity of conditions which influence health;
3) health promotion combines diverse, but complementary, methods or approaches;
4) health promotion aims particularly at effective and concrete public participation. This focus requires the further development of problem-defining and decision-making lifeskills both individually and collectively;
5) health promotion is basically an activity in the health and social fields, and not a medical service. However, health promotion can be nurtured by education and health advocacy on the part of primary health care professionals.

The similarity of thought expressed in the two sets of principles makes it appear that educating native peoples in the field of health promotion is both culturally and contextually relevant. It represents a learning enterprise which is wholistic in orientation, consonant with Indian culture, and congruent with federal government policy. While this endeavour cannot be a final answer to the problems posed by devolution, it is a viable starting point. It is also a reasonable way to address the devolution goal of "enhanced community capacity to manage health services and programs (HWC, 1985, p. 8)."

Chapter 2

Culture

Introduction

Many of the justifications and rationales given for Indian self-government in Chapter 1 involve the subject of culture. Like so many frequently used terms, the word "culture" is bandied about with assumption of mutual understanding. Unfortunately, as with Indian people in the dominant Canadian society, the subject is familiar, but not known. The intent of this chapter is to explore the term "culture" in the present-day context of Indian life. The purpose for doing this is to delineate some of the elements of Indian culture as this culture and the social milieu in which it is expressed defines the context and starting-point for any educational or social change endeavour.

Culture

There are myriad definitions of culture; none of which are truly definitive in any absolute sense. The Canadian Commission for the United Nations Educational, Scientific, and Cultural Organization (UNESCO) defines culture as "a dynamic value system of learned elements, with assumptions, conventions, beliefs and rules permitting members of a group to relate to each other and to the world, to communicate and to develop their creative potential (Roberts, 1982, p. 24)." While this definition is both positive and encompassing, it

is also somewhat bureaucratic. What it lacks is a sense of the ordinary and of the beauty and complexity of the commonplace. Sealey and McDonald (1979) touch on this simple complexity when they define culture as "the sum total of the way people live (p. 29)." T. S. Eliot, as quoted by Roberts (1982), expressed a similar view when he defined culture very broadly as "the pattern of the society as a whole (p. 23)."

Although these definitions don't supply a neat or categorical niche for culture, they imply a sense of the dynamism and interrelatedness of what is subsumed under the term "culture". Culture is not understood solely by examining its constituent elements whether they be kinship patterns, forms of music and other symbolic communication, or methods of commerce. It is understood better, though probably not completely, by sensing the creative ebb and flow of a group of people responding to their environment. Central, then, to the appreciation of culture is the recognition that it is alive. Culture is not a static construct, but rather a creative, adaptive process. Culture "itself is constantly changing and we are all part of it (Van De Vyvere, 1982, p. 50)."

Among the Indian peoples of Canada culture has followed an evolutionary path just as has the culture of the dominant non-native society. It is a mistake to think of Indian culture simply in terms of its cultural artifacts such as feather headdresses, traplines, or hoop dances. As Chief Dave Courchene stated so cogently in the

preface to Wahbung: Our Tomorrows (1971):

> ... we are a 20th century people, not a colourful folkloric remnant. We are capable and competent and perfectly able to assess today's conditions and develop ways of adjusting postively and successfully to them (p. vii).

However, to assume from this that native culture has changed to become a copy of the dominant Euro-Canadian culture is also a mistake. Even with the tremendous pressure brought to bear on native peoples to assimilate into the dominant society, they have resisted this pressure and seem "determined to remain a strong and proud and identifiable group of people (The Indian Tribes of Manitoba, 1971, p. vii)." To this end, native peoples have been selective in responding to the demands placed upon them through their contact with the people, institutions and governments of the larger Canadian society. Native peoples have borrowed heavily from the 'extrinsic' or observable elements of the more technologically advanced Euro-Canadian culture. From the 'intrinsic' or value elements of this culture they have borrowed less and more slowly. Values, according to Sealey and McDonald (1979), are a "set of interrelated ideas, beliefs, and practices to which strong feelings are attached (p. 32)." It is the strong emotional element associated with values which makes them both durable and resistant to change. Sealey and McDonald (1979) explain this conundrum as follows:

> ... The heart of a culture is its value system. ... These values are the main component of the intrinsic cultural

> items. They cannot be seen, heard or touched. Yet they are there.
>
> All the extrinsic items [of a culture] may change, and often very rapidly, but the intrinsic items, and specifically the values, will change very slowly. It is these values that often are the root cause of many conflicts in multicultrual society (p. 30).

Unfortunately, it is not only value orientations which have been a source of conflict between native peoples and Canadians of other ancestry. Part of the Indian culture which many tend to overlook is the body of legislation put in place by succeeding federal governments to both protect and control Indian peoples. While the rhetoric of the Indian Act, the British North America (BNA) Act and the present Canadian Constitution has changed from the 1800's to the present, the intent has altered little. The goal remains to integrate or assimilate native peoples into Canadian society. The Historical Development of the Indian Act (1978) by Indian and Northern Affairs states quite plainly:

> Perhaps the only perceptible change up to and including 1951 was one in semantics: Indians were now to be "integrated" rather than "assimilated". They were to become first class citizens living in the "mainstream" of Canadian society. At regular intervals, for one hunderd and forty years, essentially the same policy has been "re-discovered" and redefined to serve government objectives. However, it has only sustained failure in accomplishing what it set out to do, the merits or evils of the ultimate goal notwithstanding.
>
> The present Indian Act supposedly exists to regulate and systematize the relationship between Indian people and the majority society. Paradoxically, while it is intended to be a mechanism for assimilation, the Indian Act isolates Indian people from other Candadians (p. 193).

For Indians the Indian Act and other federal legislation

pertaining to native peoples are a decidedly mixed blessing. On the one hand, they provide for tax-fee land, social assistance, health care services, and education among other things. On the other hand, they control identity by defining who is Indian and who is not; delimit the use of land and resources; determine the type, quantity and quality of health care and education; and decide the parameters of local control by the Indian bands. The costs for Indians of receiving "special status" have been high. The price paid has come in the forms of social disintegration, loss of self-respect, independence and identity, as well as a diminished quality of life.

Quality of Life

Quality of life is as much a part of culture as are art forms and folkways. "Culture means a way of life. ... In the broad sense and of most importance, culture has to do with how we live from day to day, the quality of our daily lives (The Indian Tribes of Manitoba, 1978, p. 45)."

The 1981 Census Highlights on Registered Indians: Annotated Tables reported that Canada's native population was 499,445, with 320,160 Registered Indians, 89,935 Metis, 64,495 non-status Indians and 24,875 Inuit. Registered Indians comprised 1.3% of the total Canadian population, while native peoples as a whole comprised 2.1%. During the year of the census 61% of registered Indians lived on reserves. Two-thirds of the total registered Indian population lived in rural areas as compared to just less than one quarter (24%) of the

general population.

Indicators of quality of life covered in the 1981 census reveal a depressing situation. A selected sample follows:

- the percentage of Indians 15 years of age and over not attending school full-time who had less than grade 9 education was almost twice that of the corresponding general population of Canada (p. 24).
- the percentage of Indians aged 15 - 24 who were in school full-time was only about three-quarters that of the corresponding general population in Canada (p. 26).
- the employment rate of the Indian population (38%) was substantially lower than that of the general population of Canada (60%). The largest difference between the employment rates of Indians and the corresponding general provincial population was in Manitoba with 31% compared to 62% (p. 28).
- average individual income for Indians 15 years of age and over with income in 1980 was $7,700., three-fifths of the average ($13,000.) for the general population. Indians living in Manitoba had the lowest income at $6,100. (p. 24).
- the percentage of Indian dwellings which had more than one person per room was just over nine times that of all other dwellings in Canada. The percentage of off-reserve Indian dwellings which had more than one person per room was just over four times that of all other dwellings in Canada (p. 38).

- the percentage of Indian dwellings which lacked a central heating system was almost four times that of all other dwellings in Canada (p. 42).
- the percentage of Indian dwellings which had no bathroom was just over 15 times that of all other dwellings in Canada. The percentage of on-reserve dwellings with no bathroom was almost 27 times that of all other dwellings in Canada (p. 44).

While statistics tend to be cold, it must be remembered that this data is about human beings and the figures reflect real-life areas of concern for native peoples. The data outlined in the census have an equally dismal set of social parallels. Indian Conditions: A Survey (1980) reports that in the twenty years from 1960 to 1980 there has been "an increase in social problems among on-reserve Indians including high rates of alcohol abuse and welfare dependency (p. 3)." A selected sample of social problems identified follows:

- life expectancy, a reflection of health standards, is 10 years less than the national population.
- violent deaths are three times national levels; suicides, particularly in the 15 - 24 age group, more than six times national rates.
- the strength and stability of family units appears to be eroding, with higher divorce rates, more births outside marriage and more children in care.
- in 1964, an estimated 36% of the Indian population received

social assistance; by 1977-78, between 50 and 70 percent recevied social assistance.

- university enrolment has risen from 57 in 1963 to 2,700 in 1979, but participation is less than one-half national levels.
- between 50 and 60 percent of Indian illnesses and deaths are alcohol-related.
- Indians and other natives are over-represented in relation to their share of the population in both federal and provincial prisons. About 9% of the prison population is Indian or native, compared to an estimated 3 to 3.5 percent share of the national population. In Manitoba, Saskatchewan and the north, Indians and other natives represent upwards of 40% of the population in jails and in penitentiaries.

The pervasiveness of these social problems is intensified by the fact that the Indian population has been growing faster than the non-Indian population. "The Indian growth rate reached a high point in the late 1950's and has rapidly declined since, resulting in a 'baby boom' effect approximately 8 years behind the national 'baby boom' (Indian and Northern Affairs Canada [INAC], 1980, p. 10)." As a result, the Indian population is younger than the national population. This places greater demands on available social, health, and educational services and on the labour market at a time when resources generally are scarce and prospects uncertain due to the current economic recession.

Given the statistics related to the quality of life of native peoples, it is no wonder that Indian leaders are advocating change. However, the process of instituting change cannot be divorced from culture any more than it can be separated from economic and social development. This approach has been tried and, as the data indicate, has failed. In 1977, Perspectives Canada II made the following statement about Canada's native peoples:

> The pervasive inequality between Canada's indigenous peoples and the rest of the population remains one of the major shortcomings of Canadian society. The Indian and Inuit groups have long been isolated physically, socially, economically and politically from the mainstream of Canadian life, but the growth of native leadership and the example of other militant minorities in Canada and elsewhere has led to greater articulation of their problems (p. 279).

By 1980, when Perspectives Canada III was published, the situation had altered little.

> The 1970's were turbulent years for Canada's Indians and Metis as they emerged from decades of isolation to become one of Canada's most visible and articulate minority groups.
>
> The gulf between the economic and social conditions of these groups and the rest of the population, however, closed very little during the 1970's, and the prospects for significant improvement in the near future are not particularly bright, primarly because of population trends which will put additional pressure on the already limited housing and employment capacities of many native communities (p. 173).

The remedies to the problems facing Canadian Indians will likely be as complex as the problems themselves. Fortunately, or unfortunately depending upon your perspective, Canada's indigenous peoples are not alone in their plight. Brito (1983),

Jorgensen (1982), and Lesser (1985) detail a similar constellation of factors operating in the lives of American Indians as were outlined for Canadian Indians. Havighurst's (1984) description of the lives of Australian Aborigines is equally dismal. From a more global vantage point, Hitchcock (1985) reviews evidence indicating that "indigenous peoples are probably the single most disadvantaged class in the world today (p. 457)." Among Hitchcock's findings are:

- approximately 4% of the world's population (more than 170 million) is made up of indigenous or tribal peoples.
- these groups are neither dying out nor are they assimilated completely into the dominant societies of their respective countries.
- indigenous peoples tend to be incorporated into the socioeconomic systems of expanding states, often at the lowest levels.
- dependency on handouts or welfare is increasing.
- many members of indigenous groups now live below the poverty line.
- levels of unemployment are much higher among indigenous groups than others partly due to a lack of access to education and low literacy rates.
- indigenous peoples tend to be sentenced more severely for crimes than other people and their representation in prisons is disproportionate to their percentages of the general populations of their respective countries.

. high rates of alcoholism, juvenile deliquency and social conflict are seen on reservations and in government and missionary settlements.

To confront and to seek redress for their social and economic ills indigenous peoples began to form their own organizations to lobby for change on their behalf. Some examples include the National Aboriginal and Islander Movement (NAILM) of Australia; the Comissao Pro-Indio of Brazil; and the American Indian Movement (AIM) of the United States of America. "The goals of these organizations are diverse, but in general they seek autonomy in decision making, the right of self-determination, compensation for lost land and resources, and the freedom to practice their own religions (Hitchcock, 1985, p. 460)."

In 1975, Canadian Indians took an international leadership role through their active involvement in the inception and formation of the World Council of Indigenous Peoples (Sanders, 1977). This council was the vision of George Manuel, then President of the National Indian Brotherhood. Manuel was instrumental in organizing the first international conference of indigenous peoples held in Port Alberni, British Columbia, October 27 - 31, 1975. In addition to developing the Charter of the World Council of Indigenous Peoples, the delegates to that conference prepared and adopted a strong and poetic Solemn Declaration. (See Appendix 2 for complete a transcription.) Throughout this declaration there runs a familiar refrain the essence of which may be captured in the following excerpts:

However, they have never been able to eliminate us,
nor to erase our memories of what we were,
because we are the culture of the earth and the sky,
we are of ancient descent and we are millions,
and although our whole universe may be ravaged,
our people will live on
for longer than even the kingdom of death.

We vow to control again our own destiny and
recover our complete humanity and
pride in being Indigenous People.
(Sanders, 1977, p. 17).

Development

The universality of feeling and experience shared by indigenous peoples makes it clear that the desires and the political will arising in Canadian Indians is singular in Canada, but not unique in the world. The desire to be culturally identifiable is not a simple issue. It is interconnected with a desire for self-esteem, respect, freedom of action, and economic and social well-being. Culture cannot be separated from economic and social development. To do so rends the fabric of life and creates piecemeal action which, as experience shows, invariably misses the mark. UNESCO, in its Declaration on Cultural Policies (1983), has a strong statement on the cultural dimension of development:

> Culture constitutes a fundamental dimension of the development process which helps to strenghthen the independence, sovereignty and identity of nations. Growth has frequenty been conceived in quantitative terms, without taking into account its qualitative dimensions, namely the satisfaction of man's spiritual and cultural apsirations. The aim of genuine development is the continuing well-being and fulfilment of each and every individual (p. 80).

These are lofty words but they make a valid point. The

satisfaction of basic needs is important and the satisfaction of these needs is done within the ecological and social context that is referred to as culture. Therefore, to separate culture from political advocacy, social development, or technological advancement is to miss the essential evolutionary character of culture. "Society's desire to satisfy basic needs, and the tools it constructs in order to do so (i.e. technology), are recognized as the motor of social change. Culture, in its broadest sense, is seen as an expression of that underlying reality and, consequently, as something that must itself undergo change when the underlying reality changes (Jayaweera, 1985, p. 69)." Within Canada, the changing nature of culture was recognized by the Indian Tribes of Manitoba in Wahbung: Our Tomorrows (1978):

> We state again that culture cannot remain static. We grow and adapt to new environments and knowlege; we cannot disregard changes. But we will retain and revive those aspects of Indian culture important to us (p. 48).

The World Bank (1980) in its review of educational development in Third World countries identified trends towards the assertion of self-reliance and national identity, the emergence of broader concepts of development, as well as growing concern about the capacity of current educational systems to meet the demands placed upon them. In reference to indigenous life and culture, it notes that many "developing countries, in an effort to improve the relevance of education, are reactivating their national languages and moving toward the use of local languages in the early years of formal schooling (World Bank, 1980, p. 8)."

To be surprised then that Canadian natives are seeking self-determination and community and economic development in concert with a revival of cultural identity is to be ignorant of the wholistic nature of culture. Indians in Canada fare better than indigenous peoples in other countires in that they have assets. However, due to the nature of the legislation surrounding native peoples in Canada, their access to those resources in externally controlled. "Indians are restricted under the Indian Act . . . in the degree and manner in which they may develop and exploit reserve resources. Reserve lands are held by the Crown for Indian use, and therefore cannot be managed and exploited simply as a community asset (INAC, 1980, p. 47)."

While some may say that the Indian Act is a cultural artifact which is impeding the development of native peoples by keeping them dependent on external agencies, the Indian people themselves desire to keep it and to change it as necessary to reflect their growth as a people (INAC, 1978). Recently, with the passage of Bill C-31, native peoples have been successful in amending the Indian Act. "The Act has been brought into accord with the provisions of the Canadian Charter of Rights and Freedoms to assure equality of treatment to men and women (INAC, 1985 p. 1)." Unfortunately, other changes related to resource development and financial control are slower in coming.

In a political sense, this lack of control is frustrating to native peoples. Many Indians report "that the way band government

has evolved and the nature of financing arrangements, have tended to turn chiefs and band councils into administrators, making them less effective as political leaders (INAC, 1980, p. 83)." While this point is debatable, what must be remembered is that "Indians did not have full federal voting rights until 1960, and the last province to extend full voting rights did so in 1969 (INAC, 1980, p. 83)." Also, until 1961, Indians required a pass in order to leave a reserve for any period of time. As a nation, historically Canada is not far removed from the aparthied practices for which her federal government is condemning South Africa.

It is too early in the evolution of 20th century native Canadian culture to judge its merit as a vehicle for coping with the widespread problems of Indian communities and their complicated relationships with government and with the dominant society. As an act of good grace, hopefully any judgements made will not be through comparisons against the values, demands, and accomplishments of the dominant society. If a review of historical practices and their outcomes has revealed anything, it is that this kind of ethnocentricity produces little that is positive. If native peoples are to find their place in the Canadian mosaic, they must be allowed to do so on their own terms. As John Calihoo, former President of the Indian Association of Alberta stated in 1947: "The free will of the people expressed to their chiefs and councils must have far greater authority than in the past (Daugherty and Madil, 1981, p. 68)." Nearly four decades

later this thought and this process are still evolving within Indian communities regionally, nationally, and internationally.

Conclusion

The roots of Canada's Indian people are as deeply intertwined in social and economic fabric of this country as they are embedded in its earth. Just as one cannot abruptly uproot a plant and expect it to adapt readily to new soil, one cannot expect a people and their culture to adjust quickly to new environs and practices. Spence (1973) aptly quoted Chief Dan George of the Burrard Indians on this point:

> When the Indians of B.C. wanted to make a dugout canoe, they hollowed out a long, straight cedar log and then sought another piece of cedar appropriately shaped to provide a prow for their vessel. They brought the two pieces of wood together and rubbed the one against the other until they had a perfect watertight fit. That is how it must be with two cultures, they must rub against one another, neither giving any more than the other, until they achieve a perfect fit (p. 70).

Patience and respect are required if mutual cultural adaptation is to occur. To date, the dominant non-native society has taken the lead in this process by trying to impose its will and its ways on native peoples. The responses of native peoples and evidence drawn from the major quality of life indicators show that this approach is not successful. Perhaps, it is time for Canada to step back and to let her native peoples take the lead in shaping their own destiny.

Chapter 3

Educational Model

Devolution

A Sense of Purpose, the 1983/84 report of Indian and Northern Affairs Canada (INAC) - Manitoba Region, reaffirmed the federal government's intention to devolve its responsibilities to Indian communities. The report states:

> The process of devolving functions and responsiblities away from Indian Affairs to the control of the Indian people has become the norm. ...The thrust behind all undertakings of the Indian and Northern Affairs Canada - Manitoba Region is the eventual realization of self-controlled destiny for Indian people (INAC, 1984, p. 2).

To guide this policy into practice the department's management team "developed a comprehensive mission statement to focus the total effort and to provide the region with a unified sense of purpose within the mandate of the Department (INAC, 1984, p. 2)." The mission states:

> In partnership with the Indian people of Manitoba define and develop quality and standards of services leading to self-determination of Indian people (INAC, 1984, p. 2).

Bearing in mind that A Sense of Purpose is as much a public relations effort on the part of the federal government as it is a statement of policy and accomplishments, it seems clear that the process of devolution will continue. Progress in this direction, while uneven, has been made in the areas of education, social services, and economic development. A recent article carried by the

Winnipeg Free Press (WFP) testifies to the precarious course devolution must steer. The article notes:

> The Indian Affairs Department, under pressure to improve its accountability for money administered by Indian bands, is cracking down on band spending despite native leaders' demands for less government interference.
>
> The department has reorganized staff to administer a new policy emphasizing more monitoring and control over government [financial] contributions (WFP, July 18, 1986, p. 2).

The nature of federal legislation surrounding Indian peoples and their band operations is complex. The fact that devolution must occur within the context of government operations makes the above kind of situation almost inevitable. All rhetoric aside, government is accountable for public spending and elected officials are influenced by public opinion and media attention. Because Indian bands are almost completely dependent on public funds, their actions must come under considerable public scrutiny. Sealey (1980) makes this point in connection with local control of education:

> When local control is granted, Indian Affairs is still held accountable by the citizens of Canada through the government, for the wise and judicious use of the money allotted. The exercise of this duty by officials results in many conflicts (p. 71).

Despite the conflicts, devolution is proceeding. While Indian and Northern Affairs Canada - Manitoba Region has cited many indices of progress in its 1983/84 report, it fails to mention anything about the progress of devolution in health care services and gives only passing attention to plans for training for devolution in the areas it does cover. For example, training plans for social

development are relegated to one line: "Training assistance to Band staff will be increased to help improve skills at an operational level (INAC, 1984, p. 15)." It is unfortunate, but all too common, that development planning and forecasting typically give little attention to the areas of training and education. This continues in spite of research findings to the contrary. The World Bank's review of education in developing countries notes that studies "at the firm, farm, and project level have shown that better education, health, and nutrition can raise incomes and productivity, and that the economic rate of return to investment in schooling is high, frequently well above that to physical investment (ul Haq, 1980, p. 18)." This view is supported by research undertaken in 1983 by the Post-Secondary Career Development (PSCD) Branch of Manitoba Education. PSCD's research into the causes of high attrition rates among native students revealed that neither education institutions nor organizations representing native peoples made any concerted effort to plan, develop, and implement adequate post-secondary education programs for native people. The PSCD report further notes this lack and states:

> ... steps should be taken to have native people and institutions with responsiblity for the education and training of native people deal with the fact that education is a vital component of development and must be included in a very deliberate way in planning for economic and social development. If this is not recognized and addressed, people will become frustrated with the results of being educated or trained, only to find out that there

> are no job opportunities in their communities and probably a limited job market anywhere. Furthermore, development itself will continue to be stagnant for native people (PSCD, 1983, p. 7).

This linkage between education and development was recognized by the General Assembly of the United Nations which in 1970 resolved that "as the ultimate purpose of development is to provide increasing opportunities to all people for a better life, it is essential to expand and improve facilities for education, health, nutrition, housing, and social welfare, and to safeguard the environment (World Bank, 1980, p. 12)." This position is supported by the World Bank (1980) in its Education Sector Policy Paper. This paper makes two statements worthy of note in relation to the situation confronting Canadian Indians. These are:

1) Education has long been recognized as a central element in development. When the developing countries began their drive for social and economic development nearly three decades ago, education was perceived as a means not only of raising political and social consciousness, but also of increasing the number of skilled workers and raising the level of trained manpower. ... [In the interim, progress has shown that the] development of human resources not only helps alleviate poverty, but also contributes significantly to growth in national productivity and income (World Bank, 1980, p. 12).
2) Rapid economic growth, technological advancement, and social change transform the relationship between the individual and society and may tear down the traditional supports that have provided the social framework for the individual. The ability of individuals to identify with their changing culture and find constructive roles in society depends, to a large extent, on what education can provide by way of self-understanding, better knowledge of the choices available to society, and a critical view of the culture (World Bank, 1980, p. 14).

The World Bank's report on education emphasizes the vitality of education and its connectedness to the larger social, political and economic scene. Education is not passive, nor does it occur in isolation from the rest of what constitutes daily living. Therefore, to undertake educational planning requires considerable attention to its context - both individual and collective - and to its ramifications within the larger sociopolitical arena. This is especially true in connection with devolution where the complex relationship between Canada and her native peoples provides a veritable minefield of historical precedents, jurisdictional problems, and legalistic pitfalls.

As stated earlier, the purpose of this practicum is to develop a model for a post-secondary level program in health promotion for native peoples. The intent up to this point has been to develop an understanding of the context in which this program will be developed and to gain some perspective on variables which will impinge upon full development of the program, as well as upon students' participation in the program and their ability to enter practice upon graduation.

It is not the intention at this time to develop the program fully. The intention of the practicum is rather to formulate an orientation to program development based upon an understanding of educational theory and its correlation with the philosophy and aspirations of native peoples. This orientation will support the involvement of Indians in the development of a post-secondary

program in health promotion for native peoples.

Research conducted by the Assembly of Manitoba Chiefs (1984), the Frontier School Division of Manitoba Education (1983) and PSCD Branch of Manitoba Education (1983) is emphatic in its recommendation that representatives of Indian groups be involved in post-secondary educational planning for native peoples. The PSCD (1983) report contends that "there is a basis for establishing support and solid backing of native people and that through this relationship the problems of attrition and other associated problems will be solved (p. 2)." In the area of health care services, the authors of Wahbung: Our Tomorrows are equally insistent on their desire for Indian involvement: "Indian people must be involved in the planning and decision-making process regarding health (The Indian Tribes of Manitoba, 1971, p. 78)." Consequently, this practicum will focus on the development of a conceptual framework which will act as a harness for later, more specific, curriculum development. It is recommended that, should full program development occur, this development be undertaken with input from and under the guidance of an active Steering Committee composed of representatives of Indian bands, councils and agencies as well as experts from the various disciplines associated with the field of health promotion. To aid the work of future program planners, the final section of this practicum will outline a series of general recommendations for planning.

Post-Secondary Education

Sensitivity in educational planning for the devolution of health care services is essential to the success of any endeavour in that area. The construct called health touches on the fundamental and, perhaps, the most intimate matters of peoples' lives. Health and issues related to it interface with all those elements previously identified as cultural and contribute to the personal and community well-being so central to Indian efforts towards self-determination.

Clues to the development of a model for post-secondary education in health promotion can be found in the health promotion literature itself and in the Medical Services Branch (MSB) report (1985) concerning the adoption of this approach by Health and Welfare Canada (HWC).

Central to the World Health Organization's (WHO) philosopy of health promotion is the concept of empowerment. Empowerment involves undertaking action which supports and promotes individual and community self-development. "Health promotion stands for the collective effort to attain health (WHO, 1984, p. 5)." In its approach to implementing a health promotion policy, the WHO recommends to member states that they emphasize "a social, economic and ecological, rather than a purely physical and mental perspective on health" and that they engage in a "continuous consultation, dialogue and exchange of ideas between individuals and groups, both

lay and professional (WHO, 1984, p. 51)." Kickbusch (1981) states the WHO's health concept succinctly: "One of its main concepts now is that of participation of the individual in health care as a competent actor in a community setting, rather than by compliance (p. 4)." MSB takes up this theme in its discourse on health promotion. It states:

> The primary objective of health promotion is to inform, influence, and assist both individuals and communities so that they can assume more responsiblity for and control over health, and can be more active in matters affecting health. More specifically, the objectives of health promotion initiatives are to support and to facilitate individuals and community organizations in:
> . recognizing the importance of good health and wellness as part of everyday living necessary for the achievement of broader personal and socio-economic goals.
> . identifying and developing the means and techniques to plan and shape health in accordance with personal and community needs, values and aspirations.
> . asserting responsiblity and control over the factors affecting health and wellness (HWC, 1985, p. 19).

Consonant with this line of thinking is the World Bank's viewpoint on education: "One must think of education ... not only as a "sector" of development ... but as a pervasive element that must be integrated ... into all development efforts (World Bank, 1980, p. 14)." This view of education as a social process intimately connected to daily life is one of the prime tenets of an educational theory called social reconstructionism or social reconstruction-relevance (Eisner and Vallance, 1974). This theory has its roots in Dewey's concept of reflective thinking. "To Dewey, reflection is not merely confined within specialized domains of knowledge but is extended to social problem solving (Tanner and

Tanner, 1980, p. 11)." Hence, Dewey's concern that students learn within a "genuine situation of experience" in order to "have the opportunity and occasion to test ... ideas by appliction, to make their meaning clear and to discover ... their validity (Tanner and Tanner, 1980, p. 11)." The underlying thesis of this type of thinking and of the school of thought which eventually became known as social reconstruction "was that the school is not merely a residual institution to maintain things as they are: education has a creative function to play in the shaping of individuals and through them in the shaping of culture (Taba, 1962, p. 23)."

Specific interpretations of the theory of social reconstruction vary, but certain fundamental ideas prevail. Among these are the beliefs that schooling occurs within a sociopolitical context which should be made explicit, rather than implicit, in the curriculum and that schools have a societal role "as a bridge between what is and what might be, between the real and the ideal. It is the traditional view of schooling as the bootstrap by which society can change itself (Eisner and Vallance, 1974, p. 11)." The concept of culture as an integral and formative factor in education is also given strong play.

> ... education must, and usually does, work in the cultural setting of a given society, at a given time, in a given place, shaping the individual in some measure to participate in that society. All decisions about education, including those about curriculum, are made within the context of a society. The values and forces of that society determine not only what manner of man exists but also to some extent what manner of man is needed (Taba, 1962, p. 25).

Needless to say, within the theoretical framework of social reconstruction-relevance, there is a strong recognition of, and appreciation for, change; both in modern culture and in society. Writers and educators using this concept advocate change in the social order and believe that it is the responsibility of educational institutions to play an active and constructive role in this process. These advocates share a belief that education "must adjust its aims and program to changing conditions, and, if possible, foreshadow them, especially under the conditions of rapid change introduced by modern technology (Taba, 1962, p. 25)."

This belief in the inevitability and appropriateness of change is shared by Indian groups. In establishing the Four Worlds Development Project, native elders articulated twelve guiding principles for this endeavour. (See Appendix 3 for the twelve principles.) Second among these principles was change. They state:

> All of creation is engaged in a process of constant change. There are two general categories of change: development, or integration, and disintegration. Both are necessary and inseparably linked (Bopp and Bopp, 1984, p. 11).

This concept of change seems to permeate the writing of Paulo Freire, who is probably the best known modern advocate of social reconstruction. In Pedagogy of the Oppressed (1970), he writes:

> Knowledge emerges only through invention and re-invention, through the restless, impatient, continuing, hopeful inquiry men pursue in the world, with the world, and with each other (p. 58).

Freire (1970) sees culture as clarifying "the role of men in the world and with the world as transforming rather than adaptive beings (p. 114)."

The interconnectedness between cosmic man and his world forms a thread which Freire weaves in and out as his thoughts evolve. He contends:

> ... There would be no human action if there were no objective reality, no world to be the "not I" of man and to challenge him; just as there would be no human action if man were not a "project", if he were not able to transcend himself, to perceive his reality and understand it in order to transform it (Freire, 1970, p. 38).

This view is also shared by native peoples. The first principle of the Four Worlds Development Project is wholeness. Wholeness is described comprehensively as follows:

> All things are interrelated. This connectedness derives from the reality that everything is a part of a single whole which is greater than the sum of its parts. Hence any given phenomenon can only be understood in terms of the wholeness out of which it comes (Bopp and Bopp, 1984, p. 111).

Some criticize Freire's educational writing for its strident tone and its philosophical jargon. Unfortunately, in stressing this, they by-pass some of the subtler elements which are embedded in his work. Among these is the belief that education is a joint effort between the student and the teacher. "They become jointly responsible for a process in which they all grow (Freire, 1970, p. 67)." The basis of this educational effort rests on a foundation of mutual respect gained through dialogue. Dialogue, according to Freire, can only be truly engaging and fruitful when it grows out of

love, humility, faith, trust and hope. He states:

> Dialogue cannot exist ... in the absence of a profound love for the world and for men. ... dialoque cannot exist without humility. The naming of the world, through which men constantly re-create that world, cannot be an act of arrogance. ... Dialogue further requires an intense faith in man, faith in his power to make and remake, to create and re-create, faith in his vocation to be more fully human ... Without this faith in man, dialogue is a force which inevitably degenerates into paternalistic manipulation (Freire, 1970, p. 77).

On the subject of trust, Friere (1970) is crisp in his view that it is the bedrock of the humanitarian: "A real humanist can be identified more by his trust in the people, which engages him in their struggle, than by a thousand actions in their favor without that trust (p. 47)."

This is not to say that Freire's view of humanity is simplistic, naive or uncritical. Freire promotes critical thinking and thorough analysis as the basis for action. He values "education which stimulates the critical faculties and is not content with a partial view of reality but always seeks out the ties which link one point to another and one problem to another (Freire, 1970, p. 60)."

In his work among the poor and illiterate in Brazil and later in Chile, Freire sought to instill, among other things, a sense of dignity. He used education as a means to empower people by making them conscious of the factors operating within themselves and within their environment which created and sustained their world view. Through critical thinking and dialogue on topics pertinent to and, usually, generated by his students, he attempts to broaden their

perspective and to focus their attention positively on their ability to change their world. He states:

> ... This pedagogy makes oppression and its causes objects of reflection by the oppressed, and from that reflection will come their necessary engagement in the struggle for their liberation. And in the struggle this pedagogy will be made and remade (Freire, 1970, p. 33).

Although Friere (1970) frequently refers to revolution, he does not see revolution as simply the overthrow of one regime and its replacement by another. He contends that if "the goal of the oppressed is to become fully human, they will not achieve their goal by merely reversing the terms of the contradiction, by simply changing poles (p. 42)." True revolution is found in the transformation of the values and beliefs which established the 'poles' of society in the first place. Doing this requires greater strength than that of mere weaponry. It requires strength of character arising from a solid belief in the essential goodness and intelligence of mankind. "The dehumanization resulting from an unjust order is not a cause for despair but for hope, leading to the incessant pursuit of humanity denied by injustice (Freire, 1970, p. 80)."

Thus Freire touches upon "the idea that education is a moral undertaking (Taba, 1962, p. 25)." This idea is fundamental to social reconstruction theory. It is also fundamental to the philosophy of the Four Worlds Development Project. Numbers five through nine of the guiding principles of this project deal with humanity's infinite potential to transcend limitations and to

transform the world. This view may be encapsulated by principle number twelve which attests to mankind's ability to overcome fear and to struggle with the unknown in order to bring order to what may appear to be a chaotic universe. Principle twelve is:

> The essence of human actualization is the process of coming to know and to love the ultimate unknowns underlying the ordering of the universe. This is an infinite process. It may be expressed by individuals as well as by human collectives (Bopp and Bopp, 1984, p. 112).

While Freire's thought shares some commonalities with that of the native elders who laid the philosophical groundwork of the Four Worlds Development Project, it is important to remember that his concepts evolved in a context which is very different from that facing Canadian Indians. Sanders (1977), in reviewing the formation of the World Council of Indigenous Peoples, notes the disparity between the experiences of indigenous peoples from Central and South America and those from other parts of the world. He states:

> The Sami, the North American Indians, the Inuit, the Maoris and the Australian Aborigines could understand each others' situation quite easily. But the relationships between these groups and their national governments were paradoxical, perhaps incomprehensible to the delegates from most of Latin America. Correspondingly, the political tension within which Indian organizations functioned in Latin America was difficult for the other delegates to appreciate. Perhaps it was most graphically conveyed when it was learned that people who had attended the Port Alberni meeting had faced imprisonment and, in at least one case, torture after their return to Latin America (Sanders, 1977, p. 23).

This treatment of indigenous people conveys a political attitude which is a far cry from that of Canada's federal government

which actively supported and endorsed the Port Alberni conference. It, therefore, behooves us to gather the pearls of Freire's wisdom which have been examined so far and to look for educational approaches which better reflect Canada.

Among the most notable and most enduring Canadian proponents of social reconstruction was M.M. Coady of St. Francis Xavier University. In the 1920's and 1930's, Coady spearheaded a cooperative movement among farmers and fishermen of eastern Nova Scotia. Through study groups lead by staff of St. Francis Xavier University, these people identified concerns thrust upon them by the economic depression, rapid urbanization, and industrial mechanization and sought realistic and productive solutions to these problems. Lead by educators, many of whom, like Coady, were also clergymen, these poor, often barely literate, people established cooperative lobster processing plants, sawmills, stores, and fruit canning factories. Through persistent effort, often in the face of great difficulty, Coady and his staff in the Extension Department of St. Francis Xavier breathed life into their "theory that the common man can be at once a worker, a student, a businessman, and an intelligent citizen (Coady, 1939, p. 53)."

The parallels between the situation confronting Coady and his adult students and that facing Canada's native peoples are striking. First of all, Coady and his staff educated adults who were largely from relatively poor and isolated rural communities. "Seventy-one

per cent of all bands, representing 65 per cent of the total registered Indian population, are situated in either rural or remote locations (INAC, 1980, p. 12)." Secondly, Coady worked with tremendous ingenuity, but few resources. The great depression had destabilized an always precarious economy. Big business was growing and people were becoming dependent on it and the services it provided to determine their economic destiny. This disrupted many of the social systems which had evolved as mechanisms for maintaining community cohesion. The result was an increase in urban migration and a subsequent increase in the number of urban poor. "Another result of over-service and the degree to which control of the people's economic destiny has slipped away from them is loss of dignity of the ordinary man's place in society (Coady, 1939, p. 23)."

Although, among Indian groups nationally, urban migration appears to have stabilized, social conditions reflect the stress disruption of the ecological base of their traditional economy has created. This stress is reflected in lifestyle indicators reported in the 1981 Census Highlights on Registered Indians. Use of social assistance is high, poverty is the norm, and wages earned by Indians are considerably lower than national averages. This situation is made more distressing and urgent by "increasing evidence and awareness of environmental damage, pollution and disruption of Indian ways of life by industrial activities and recent major resource development projects (INAC, 1980, p. 9)." Native leaders and government officials give many reasons for extant conditions in Indian communties including:

- lack of an independent economic base in Indian communties;
- too rapid development after years of isolation and political dependence;
- government programs, particularly social assistance, which have tended to reinforce a sense of dependence;
- limitations placed upon Indian utilization of resources on reserves by the Indian Act (INAC, 1980, pp. 9 and 47).

In Masters of Their Own Destiny (1939), Coady states that people have to look to themselves for solutions to their problems. He contends:

> ... He [i.e., the common man] may at first look to the vested interests to remake society, but society as it is has given these groups their power and it is unlikely that they will care to change it. The next hope may be that the generation growing up, the object of so much formal education and careful training, may remodel the framework of our present life. Children, however, do not control the world. ... The resposibility lies with the ordinary adult population ... (Coady, 1939, p. 41).

Coady's commentary on the nature of vested interests and their disinclination towards change has its counterpart in Freire's work. Freire contends that there is no such thing as a neutral education. Education in institutional settings is typically value-laden and the values it transmits are those of the dominant social order. He believes that educators "cannot liberate the others, people cannot liberate themselves alone, because people liberate themselves in communion, mediated by reality which they must transform (Davis, 1981, p. 62)." This means that people must develop their own understanding and assert that understanding in order to change their

world. Within Indian communities, this developing understanding is reflected in the move towards local control and in native peoples' determination "to remain a strong and proud and identifiable group of people (The Indian Tribes of Manitoba, 1971, p. vii)." The idea of the importance of communal understanding and communal effort recognized by Coady and Freire is also recognized by native peoples. Wahbung: Our Tomorrows states:

> It is generally recognized that the strength of society rests with the inter-dependency of people, one upon the other, and the development of the community of interest that exists between all people to pursue progress and a better way of life. For the Indian this will mean a conscious effort to develop inter-relationships that have for a century been inhibited by continued state control (The Indian Tribes of Manitoba, 1971, p. xvi).

Coady (1939) believed that human "life is so important that to change the attitudes and thinking of even one man for the better is to effect a noteworthy miracle (p. 49)." However, he did not believe that change, if it is to be truly beneficial, can be undertaken by prescription or by decree. To be relevant and ultimately successful, the direction and type of change can only be determined by those who are to be affected by it. Therefore, in their work, Coady and his staff evolved an orientation reflective of the principles of adult education and cognizant of the exigencies of daily life. This may be encapsulated as follows:

> The Extension Department has followed the assumption that every ordinary man or woman is a potential student and every small group of people a study club. It presumes that once the people have learned to solve their most pressing problems they will have then tasted the

> delicious fruit of self-accomplishment which will spur them to the solution of all other problems of life. It is sufficiently realistic to know that "not alone by bread does man live", but certainly not without bread. It follows the psychological principle that education to be effective must have a specific objective and that it must be related to the situation which confronts the learner at the time of study. Furthermore, it is based on the educational principle that we learn by doing, and by doing the things that bother us, or whose solution needs attention. It presupposes the sociological doctrine that man is essentially a social being, that he finds his best expression in the group and that cooperative study paves the way for cooperative living (Coady, 1939, p. 65).

While some may look at Coady's views and question their validity nearly forty years later, a closer examination will reveal that his thinking is congruent with that of more modern educational writers such as K. Patricia Cross (1981) and Malcolm Knowles (1973). Cross points to the pragmatic nature of adult learning, while Knowles lauds the essential uniqueness, independence and creativity of adult learners. A further testament to the value of Coady's approach is the success of the Coady International Institute established at St. Francis Xavier University in 1959 and actively involved today in training for social leadership and social development in many Third World countries.

As a social reconstructionist, Coady leaned more to the adaptive, rather than the revolutionary end of the change continuum. He regarded ideas as "more powerful that bullets (p. 52)." He believed in the painstaking precision of purposeful action directed at a specific outcome. On the subject of revolution, he states:

> Thinking is difficult; and the persistent effort required to carry out a program which calls for the

> manipulation of the more subtle and powerful forces, the economic, political, cultural, and spiritual, is more difficult still. The revolution seems to be the easy way to solve the social problem, but that it can do so is a myth and a delusion. ... Force has not the precision that is needed. We need to be as exact in social architecture as we are in building material structures (Coady, 1939, p. 136).

Masters of Their Own Destiny delineates an educational process whereby people are empowered through their abilities to learn, to problem-solve, and to act individually and collectively for the betterment of society. It is a complex, but positive strategy which, to borrow Freire's term, is liberating in its intent. It is an approach which is interwoven with the threads of daily life and the cultural nuances of society. It is interesting in this context that Coady regarded culture and education as synonymous: "Culture is growth of personality. It is a realization of possibilities and in that sense is synonymous with education (Coady, 1939, p. 115)."

In terms of the field of health promotion, Freire's and Coady's emphasis on the social and cultural character of learning is uniquely relevant. In examining the social paradigm of health, Kickbusch (1981) notes that the lesson of the last decade for the health educators at the WHO has been that "social integration and social support, or even broader a sense of social coherence for belonging, seem to be central to wellbeing, no matter if a person is healthy in our sense of the word or not. Social wellbeing is the wellbeing of people in their social relationships (p. 6)." She

identifies the most salient features of a social model of health as:

- recognizing the limitations of a professional, essentially industrial model of health and moving towards an approach which incorporates community involvement. "At the beginning of the 1980's it is becoming increasingly clear that health is not just a thing between doctors and patients, it is a total care resource (Kickbusch, 1981, p 6)."
- being realistic about the fact that for many pople, health is not the highest goal in life.
- believing in self-reliance as an expression of human dignity and development.
- recognizing that there is more than one form of curing or healing. "Forms of successful intervention must take into account a holistic view of health and illness and be integrated into a complex whole (Kickbusch, 1981, p. 6)."
- undertaking social action without demanding or imposing social control.

These principles are akin to those of Freire and Coady as well as to other exponents of social reconstruction-relevance and social learning theory. "In this family of theory human nature can be said to be interactive with the environment (Vojtecky, 1984, p. 251)." The causes, therefore, of problems are to be found in the nature of this interaction and solutions derive from the ability to change,

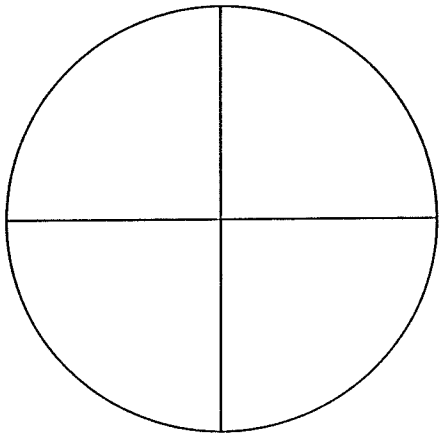
modify, or recreate these interactions. Native elders in guiding the formation of the Four Worlds Development Project gave project workers some advice which summarizes and adds a spiritual dimension to this idea: "Their guidance instructed us to look to the root causes of the problem which, they said, are found in the basic relationships that we, as human beings, have with the universe and with each other (Bopp and Bopp, 1984, p. 113)."

The essential ability of human beings to form meaningful relationships with each other and with their environments and thereby to engage in the creation, re-creation, and transformation of that environment runs like a theme throughout the work examined so far. If one thing is evident from this, it is that a model for post-secondary level education in the field of health promotion for native peoples cannot be a linear one. The constituent elements, both process and content, of the health promotion concept as articulated by the WHO are wholistic in nature. Native viewpoints on the subjects of health and education advocate community involvement. The work of social reconstructionists like Freire and Coady demonstrate the value and power of collective thought and action. All this militates against linearity in educational development and points towards the delineation of a cyclical process; one which can be both interactive and generative.

A key to the development of such a model can be found in native tradition. A metaphoric tool used by native peoples to explain the interactivity of humans and the environment is the medicine wheel.

The medicine wheel is represented graphically as follows (Figure 3.1) and is noteworthy in that it is "found in some form in the graphic art of nearly every tribe in North and South America (Bopp and Bopp, 1984, p. 109)."

Figure 3.1: Medicine Wheel



SOURCE: Four Worlds Development Project-Overview (1984) by M. and J. Bopp, p. 108.

Michael and Judie Bopp (1984) explain the symbolic significance of the medicine wheel as follows:

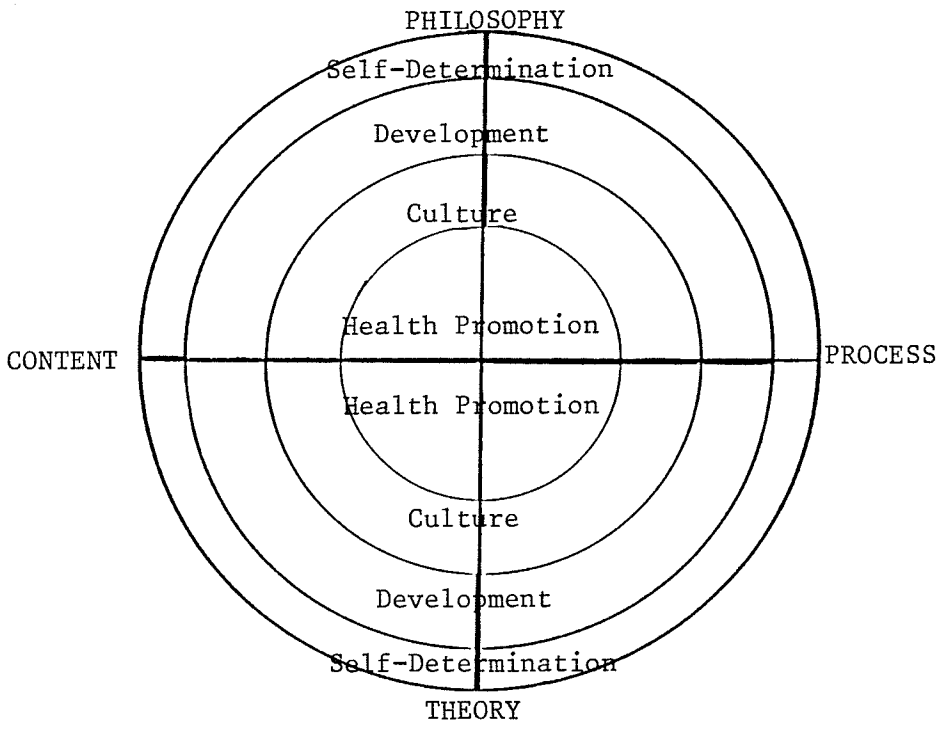
> There are four points on this circle, representing at different times the four directions (each symbolizing qualities of a complete human being); the white, yellow, black and red races of humanity; the four worlds of existence (the mineral, vegetable, animal and human worlds, all bound in the unity of spirit); the four environments with which human beings must interact (the physical environment, the human environment, the self and the unknown); the four dimensions of human potentiality (the physical, emotional, mental and spiritual dimensions, all converging at the intersection within us, known as the human will); the four dimensions of human knowing (action, reflection, interpretation and understanding mediated at the intersection of these activities by the world-shaping power of belief and vision). There are of course, many

> more sets of four that fit within this analytical framework ... But it is easy to see that the medicine wheel has far-reaching explanatory powers (p. 109).

In terms of the theory of social reconstruction, the medicine wheel concept can be seen as explaining the convergence of philosophy, theory, content, and process or methodology. Mediating the convergence of these educational elements are generative or epochal themes which can be derived from the context of Indian life as it merges with that of the larger Canadian social scene. The concept of generative themes is derived form Freire's writing. He regarded generative themes as descriptors of the predominant forces operating within a given culture at a given time. These themes are complex and incorporate the identification of limiting factors operating within the individual and collective milieu and strategies to overcome these limits. Friere (1970) sees generative themes as "located in concentric circles, moving from the general to the particular (p. 93)." The image this evokes is rather like the ripple-effect created by throwing a stone in water.

In terms of health promotion education and native peoples, generative themes might include the health promotion concept itself as well as native culture, economic and social development, and local control. All these relate to the idea of empowerment which is central to the WHO's concept of health promotion, Freire's and Coady's concept of social reconstruction through education, and Indian peoples' efforts toward self-determination. Graphically, this particular medicine wheel may be represented as follows:

Figure 3.2: Health Promotion Medicine Wheel



Developing curriculum using the model outlined in Figure 3.2 will not be easy as this model implies sensitivity to the pulsations which characterize the ebb and flow of life. They are steady and nourishing, but can be impeded by force and self-interest.

Conclusion

Prior to selecting the theory of social reconstruction as the starting point for developing a model for post-secondary education in health promotion, many other theories were examined. However, they proved limited in addressing the context of this educational

endeavour as outlined in Chapters 1 and 2. Approaches to multi-cultural education were also examined and found wanting. They tended to concentrate on language training and appeared to assume a deficit on the part of the learner (Gibson, 1984). This assumption of a deficit position on the part of the learner seemed antithetical to the concept of health promotion endorsed by the WHO and its member states. It seemed important, therefore, to evolve a concept and a philosophical orientaton which underscored the concept of health promotion as "positive, dynamic, and empowering (WHO, 1984, p. 6)." At the same time, it was important not to generate only rhetoric and idealism instead of constructive thought and action. Consequently, the choice became to select a theoretical base which was grounded in some form of realism. A quote from Masters of Their Own Destiny expresses this concern quite definitively: "Better to have action with some failures than no action for social improvement. Ignorance and inactivity are criminal in these times of stress (Coady, 1939, p. 64)."

Chapter 4

Background for Planning

Health Education

A survey, undertaken prior to the initiation of this practicum, revealed that there are three universities in Canada teaching baccalaureate-level programs in the health education/health promotion field. These are Dalhousie University in Halifax, Nova Scotia, the University of Waterloo in Waterloo, Ontario, and the University of Regina in Regina, Saskatchewan.

The program at Dalhousie University has four options: health education for elementary schools, health education for secondary schools, administration and evaluation, and lifestyles education. While the elementary and secondary school options prepare students to work in the educational system, the administration and evaluation and lifetyles education options prepare students for employment in a variety of health and social service agencies. According to Richard Beazley, head of the health education program at Dalhousie, the instructional approach in the four options is interdisciplinary with students taking courses offered by the faculties of education, physical education, business administration, medicine, arts and sciences (Interview conducted in August, 1985).

The Health Studies program at the University of Waterloo has five streams. These include health promotion, health administration, environmental health, biomedical, and health studies/kinesiology.

Once again, the instructional approach is interdisciplinary with students having to complete a number of core courses prior to beginning their chosen stream. Graduates of the Waterloo program find employment in a number of health, education, recreation, government and social service settings.

The prime emphasis in the health education program at the University of Regina is school health. Graduates of the program receive a Bachelor of Education degree which allows them to teach health and related subjects in the elementary or secondary schools of Saskatchewan. This program does not have the interdisciplinarity of the Dalhousie University or the University of Waterloo programs. However, students are able to take some subjects in the faculties of arts and sciences. According to Gerald Gray, professor of education at the University of Regina, a number of students in the program have prior training in the health field (nursing, dental assisting or pharamcy) and enter the program in order to obtain a degree (Personal correspondence received in October, 1985). Aside from education, employment opportunities for graduates of the Regina program exist in hospital and related health care settings, government departments, and social service agencies.

In the United States, where health education and health promotion are more established disciplines, there are numerous programs in these and other related fields. A recent directory compiled by the Association for the Advancement of Health Education

(AAHE) listed a total of 312 institutions in 46 states offering undergraduate and graduate programs in school and community health education. While educators in Canada may envy the bounty of the United States, it is doubtful whether Canada has the economies of scale required to support vast numbers of professional caliber programs in health promotion.

Within Canada and also in the United States, there is growing concern that health education be professionalized and set apart as a separate and distinct discipline. To facilitate this process, a number of role delineation studies have been conducted. Role delineation is defined as "a process for specifying what responsibilities, functions, and activities are characteristic of the role in question: in this case the role of the health educator (Beazley and Belzer, 1984, p. 3)."

To determine the progress towards professionalization of health education in Canada, Beazley and Belzer (1984) undertook just such a role delineation study. They discerned a number of interesting developments in the field of health education. Among these were:

- health education as a profession is, in may respects, a product of the information age with its rapid generation and dissemination of information related to health;
- a baccalaureate degree is typically the entry requirement for practice in health education;

- health education provides a stable occupation for its practitioners, usually in combination with related administrative, instructional, programming, and care responsibilities;
- there is "a generic role for all entry-level health educators in Canada, regardless of work setting. It includes: assessing the need for health education, planning health education programs, co-ordinating planned health education programs, providing direct health education services, evaluating health education, and continuing to develop professionally. The area of resonsibility concerning organizational and social development ... is included ... because its importance is emerging (Beazley and Belzer, 1984, p. 15)."

In exploring this generic role, Beazley (1984) identified the mission of health education. This mission is "viewed as enabling people, individually and collectively, to make and act upon informed decisions about matters affecting their personal, family, and community's health (Beazley, 1984, p. 6)." This mission is distinct from that of other health related disciplines in that it does not prescribe or treat physical ailments nor does it restrict its purview to the physical and mental aspects of individual and collective life. The broadness of this health education mission, along with its emphasis on "enabling" rather than "doing for" others, makes it quite compatible with the parameters of health promotion as defined by the World Health Organization (WHO) in 1984.

The concern for defining the mission and role of health education and for determining the state of professionalization of this field found earlier expression in the United States than it did in Canada. In 1978, the United States government funded a national Role Delineation Project for Health Education. "Role delineaion studies were initiated by the federal government in response to increasing numbers and capabilities of "new" health professions (Henderson, 1982, p. 5)." The purpose of the Role Delineation Project was the identification, refinement, and verification of the competencies required and used by practitioners in the field of health education. "Refinement refers to the initial process of reviewing the initial role specification ... and making revisions based upon comments from professionals and from in-depth interviews with practitioners. Verification refers to a more precise process of gathering data from practitioners through the administration of a survey based upon the refined role description (Henderson, 1982, p. 8)."

To better conceptualize their findings, the Role Delineation Project for Health Education, in its preamble, described the functions of health education as follows:

> Based upon scientific priniciples, health education employs planned learning opportunities to influence change. The process of enacting change is complex and requires skilled application. As a major part of the health education process, health educators work with consumers and professionals to promote, protect, and improve health through skillful use of scientifically sound health knowledge applied in planned learning

> opportunities to meet perceived needs. Learning, as a process of change, is directed towards helping prople to achieve and maintain an optimal level of health, to prevent the occurrence of disease and debilitating conditions, and to minimize the impact of such diseases and conditions when they do occur.
> ... Techniques and tools used to provide health education services include personal counseling, the mass media, a variety of instructional skills, group process skills, community organization and development strategies, and a range of other educational methods. In order to perform his/her role adequately, the health educator's academic preparation must include both content and process. ... Health educators should also be prepared to understand and assist in administrative, budgetary and policy decisions (Henderson, 1982, p. 14).

The comprehensiveness of this description is supported by the broad array of knowledge and skill competencies identified through the project. A summary of the major role specifications follows:

. Working with individuals, groups and organizations, the health educator:

I. Assesses the need for health education

A. Identifies health-related data about social and cultural environments, growth and development factors, and needs and interests of defined populations.

B. Analyzes information to determine areas of need of defined populations.

C. Identifies potential targets for educational intervention.

II. Plans health education programs

A. Participates in the planning process.

B. Gains support for the program.

C. Develops program objectives.

D. Designs educational programs to meet specified programs.

III. Co-ordinates planned health education programs

A. Carries out designated administrative activities for the health education program.

B. Maintains support of other staff for health education programs.

C. Acts as a facilitator.

D. Assists other staff and/or volunteers responsible for carrying out health education activities.

E. Advocates for health education.

IV. Provides direct health education services

A. Employs educational methods designed for a specific audience.

B. Monitors education activities.

C. Serves as a resource person.

V. Evaluates health education

A. Designs plans to access educational methods and achievement of educational objectives.

B. Implements evaluation plans.

C. Interprets the results of evaluation.

VI. Promotes organizational and social development

A. Works with others to modify policies of institutions, agencies and/or groups to more effectively meet identified needs.

VII. Continues to develop professionally

A. Implements career plans.

B. Improves professional competencies.

(See Appendix 4 for a complete listing of the role specifications.)

In the area of knowledge essential to quality practice, the Role Delineation Project for Health Education noted competencies, too numerous to list, in the behavioural sciences, health sciences, and health education. (See Appendix 5 for the knowledge inventory.)

It is evident from the data gathered by the United States Role Delineation Project that the knowledge and skill competencies required by an entry-level health educator are extensive. Evidence from this project also reveals that as an individual progresses in this field either academically or in practice the required competencies become increasingly sophisticated. The setting in which a health educator practices also appears to influence the type and range of competencies required. Henderson (1982), in his report on the activities of the Role Delineation Project for Health Education, observes that "responses from health educators working in community and medical care settings showed greater similarity to each other than those of school health educators. ... This difference was interpreted to mean that working environments influence the application of the health educator's skill (p. 13)."

Post-Secondary Education in Health Promotion

Once again research brings us back to the importance of context. While there is much that a post-secondary program in health promotion for native peoples can learn from the field of health education, it is paramount in the development of this program that a watchful eye by kept on the context of native peoples' lives. This context forms both the starting and terminal points of the educational process.

Interviews conducted to gain background for this practicum as well as the experience and research of the Post-Secondary Career Development (PSCD) Branch of Manitoba Education and the Frontier School Division indicate that, while post-secondary education is more accessible to native peoples, the failure and attrition rates for native students remain extremely high. (See Appendix 6 for a list of persons interviewed.) For the sake of clarity, it should be noted here that the Frontier School Division is the branch of Manitoba Education charged with the responsibility of delivering elementary and secondary education in some Indian communities in Manitoba. PSCD is that arm of government responsible for extending the opportunities of post-secondary education and training to the disadvantaged. This department was created in 1974/75 and given a mandate "to make a way for motivated but disadvantaged individuals to enter into and take full part in the economic life of the Province. The major tasks have been to identify people who both

need and are capable of succeeding in post-secondary training, to identify areas of training which will lead directly to meaningful employment and to develop programs which will make access to these jobs and professions possible (PSCD, 1986, p. 1)." In co-operation with the various universities and community colleges in Manitoba, PSCD has run a number of programs including diploma or degree programs in nursing, social work, education, medicine, and engineering. It has a retention rate of 79% with a client group consisting entirely of rural and urban native peoples and the inner-city poor, primarily single parents.

In the executive summary of a report on attrition rates among native students, PSCD (1983) notes that while "there have undeniably been some gains in solving the attrition problem, the gap exists and may even be growing. While some programs have had limited success, others have had little, if any, impact on the problem (p. 1)." Estimates from Manitoba's community colleges place the attrition rate for native students at as high as six times that of non-native students. Lee (1983), in her study of the accessibility of post-secondary education to graduates of the Frontier School Division, supports the findings of PSCD. She concludes that accessibility is not the critical issue it once was. Instead, attrition proved to be the issue requiring examination and resolution. She explains:

> It appears that, potentially, post-secondary education is widely available to students from Frontier School Division. The major barriers to students are

> social and cultural ones, not financial or institutional. Consequently, the issue is not limited to increasing post-secondary participation, but directly concerns assisting the increasing number of students who are becoming post-secondary participants (Lee, 1983, p. 2).

These facts indicate the need for extensive support systems to help native peoples adjust to their new academic and home-life environments. Lee (1983) notes this lack and its impact on native students. She states: "Students entering post-secondary institutions often arrive in new and strange settings and no one is available to help them cope. They stay a short period and often do not complete a progam of studies (Lee, 1983, p. 10)."

It is a mistake to jump to the conclusion that post-secondary educational institutions do not provide support systems for their students. Anyone who has attended such an institution knows that this is not the case. Supports in the form of counselling services, learning assistance centers, recreational facilities and libraries are present in most such institutions. However, their effective utilization requires a fair amount of confidence and sophistication. Therefore, the problem with support systems is not that they are not available. It is that to native peoples, especially those coming from remote areas, they are not readily accessible and/or effective.

Fulham (1976), in his study of the migration of native people to urban centers, identifies the following barriers to Indians using available services:

- ignorance about what services are available or appropriate;
- lack of knowledge about how to proceed to get help;
- transportation and child-care problems which prevent visiting of agencies;
- frustration and anxiety over residency requirements, delays, and the completion of many forms;
- reluctance to visit agencies where few, if any, native people are likely to be found;
- embarrassment over personal appearance resulting from inadequate or inappropriate clothing;
- unwillingness to ask questions for fear of being embarrassed.

In relation to urban adjustment, Fulham notes that native people usually seek help from friends or relatives. Unfortunately, this may not provide much real assistance "because in many cases the friends or relatives used are often no more adjusted than the individuals seeking assistance (Fulham, 1976, p. 30)."

The picture Fulham paints of the difficulties encountered by native people moving to urban centers finds its counterpart in their efforts to utilize post-secondary education. Ariano (1984), in reviewing the counselling approach used at the Saskatchewan Indian Federated College, an affiliate of the University of Regina, points to the need for an active counselling process which encompasses issues such as housing, transportation, medical care, fiancial assistance, and personal supports. That these are as critical to

native students' success as their grasp of academic material is affirmed by the work of PSCD Branch in Manitoba. In their programming PSCD builds in three categories of supports: academic, social and financial.

While academic support has not been mentioned specifically to this point, it is generally understood, and was noted in Chapter 1, that native students lag behind non-native students in the areas of science, mathematics, and language arts. The majority of those interviewed for this project noted this deficit and recommended remediation to help address this situation. Lee (1983), in her study, states that "Frontier high schools are not able to offer a full range of Science credits (p. 12)." The Assembly of Manitoba Chiefs (1984), in their education report, notes these deficits and indicts the present educational system for failing to prepare native students for a future which appears to be increasingly technical in scope. They note:

> Few of those who do graduate [from high school] have the necessary vocational and science courses to allow them entry into the related post-secondary training and jobs of the technological 1980's. Fewer still possess the broad academic skills needed for successful university work (Assembly of Manitoba Chiefs, 1984, p. 3).

In terms of the development of a post-secondary program in health promotion for native peoples, appropriate academic support is essential. It is recommended that such a support program be integrated with the regular academic stream in order to maintain the relevance of the program. This approach has been tried by PSCD

Branch at various community colleges in Manitoba and is proving to be quite successful. PSCD maintains a perspective on the education of the disadvantage which precludes the "ghettoizing" of their programs. The department states:

> No concessions are made for program students in terms of academic rigor. Wherever possible they enter the classroom with regular students and compete with regular students for grades and the teachers time. ... Wherever possible the projects avoid taking up students time in non-credit upgrading classes because there is little correlation between success in upgrading and success in regular classes (PSCD, 1986, p. 7).

Social and financial supports are also critical to students' success. In a program developed around the dual themes of wholism and empowerment, it is important that any support system developed be both active and comprehensive. Such a support system must regard as its purview teaching a person to negotiate a bus system, to locate affordable housing, to find a doctor or a dentist as much as to use the resources of a library or to maintain an academic schedule. PSCD (1986) has found that "among those who drop out of the projects, personal reasons account for the largest group (p. 8)."

The importance of financial support for native students cannot be overlooked. Most Indian students come from poor backgrounds and many who seek post-secondary education are single parents (Ariano, 1984). Financial assistance enables these students to meet their family obligations while attending an educational institution. PSCD uses a schedule by means of which students' financial support is

determined on the basis of need. "The aim is to provide sufficient financial support to ensure that no student drops out for purely financial reasons (PSCD, 1986, p. 8)."

Concomitant with an examination of support systems, the developers of a post-secondary program in health promotion must look closely at the area of curriculum. Curriculum for the purposes of this project is defined as "a structured series of intended learning outcomes. Curriculum prescribes (or at least anticipates) the results of instruction (Johnson, 1967, p. 129)."

In developing curriculum, a signficant caveat can be found in the WHO's experience in the development of learning materials in Third World countries. This agency has found that local involvement with projects is vital to their continuity and success. Simply putting money into a project is rarely enough. It has been the WHO's experience that the "production of health learning materials must clearly be part of an integrated plan for health manpower development" and that, unless there was genuine national and local involvement in a project, "projects failed ... when the external funds had been exhausted (Dowling and Ritson, 1985, pp. 171 and 174)." The lesson here for Canada is to involve representatives of Indian communities and agencies in the curriculum development process. To be effective, this involvement must be real and substantial rather than merely political. Native people can make a significatnt contribution to the health promotion curriculum by

defining areas of need for practice and by determining the applicability of learning content to practice within the context of Indian communities. This will help not only to maintain the cultural relevance of the curriculum, but also to build support for the program and to initiate interest in hiring program graduates.

Also, in the area of health education, the WHO has found that in "fostering self-reliance it is important that health professionals should realize the importance of the approaches they use and the danger of becoming part of the cause of dependence (Hygie, 1984a, p. 57)." This is very significant in terms of educating native peoples who have been living since birth within the framework of a system which fosters dependence. Curriculum developers must be cognizant of the parameters of the systems which, in many respects, determine the scope of action available to Indians and, at the same time, realistic about what steps native peoples want to take to empower themselves. Empowerment as a phenomenon may have to be dealt with explicitly so that students can develop the skills and abilities necessary to chart a course for themselves and for the communities they may represent towards their vision of self-determination.

International experience in primary health care reveals that even the best policies can remain only paper without competent personnel to implement them (Hygie, 1984a). To implement the devolution of health care services, skilled professionals are necessary. However, technical competence is not enough. To

implement a health promotion program requires individuals skilled as educators and change agents and finely attuned to the nuances of Indian life. While many bright and sensitive individuals may be able to develop these skills, only Indians can know intimately what it means to be Indian in Canada. This cultural distinction, which may be known more at an emotional than a cognitive level, grants native health professionals entry to native communities in a way that, except in rare instances, is denied members of the dominant Canadian society. Spence (1973) expresses this kind of distinction when discussing the significance of the English language to native peoples. He states:

> I realize that non-Indian languages, particularly English and French, are more widely spoken than any Indian language. But the point I want to make here is that to the Indian who is Saulteaux, both French and English seem mainly to have a "tool" value. But as English can only be to an Englishman, so Saulteaux is to the Indian - the language of emotional attachment (Spence, 1973, p. 61).

Herein lies the subtle distinction felt when reference is made to a "home" as opposed to a "house".

Therefore, in developing curriculum for a post-secondary program in health promotion for native peoples, native peoples must be involved from the outset. This involvement is essential to the vitality of any program developed. It is also critical to the ability of program graduates to be effective educators. Education is central to the translation of health promotion philosophy into practice. Within the field of health promotion, there is a

fundamental need "for personnel who will introduce the educational dimension in all aspects of their work (Hygie, 1984a, p. 57)."

In developing educational or training programs in the health care field the WHO advocates an approach which can be summarized as follows:

> To develop or improve the qualifications of personnel, training programs should apply the same methods that health care providers are later expected to use with the community. They should therefore enable trainees to take on more responsibility for their own training instead of being passive learners, and provide opportunities for health and other workers to learn together, so that later they can work together ... and appreciate their respective responsibilites in the promotion of health (Hygie, 1984a, p. 57).

This viewpoint implies an educational approach which is both interdisciplinary and practical. It is designed to build competence in as realistic a setting as possible. For curriculum, this kind of thought may find expression in an educational design which incorporates practica or field placements as part of program course work. It may also be expressed in a program design which utilizes principles of cooperative education. Either approach is valid. The University of Waterloo has a cooperative education option in their undergraduate Health Studies program. Dalhousie University employs field placements as part of their Health Education program. The tradition of field placements to assess students' progress and skill attainment is well established at the University of Manitoba in the faculties of education, social work, and nursing in their undergraduate programs.

As far as the identification of learning content is concerned, curriculum developers can turn to Indian communities for the identification of the kinds of knowledge and skill needed by a graduate in health promotion. Precedents exist for such an undertaking. The Indian Mental Health Research Formulation (1985) identified 34 characteristics which Indian people in Manitoba believe are important for social service and health care providers to possess in order to work effectively in native comunities. Although the emphasis in this study is on mental health, many of the characteristics listed are compatible with the areas of competence implicit in Kickbusch's (1981) social model of health outlined in Chapter 3. These include:

- must "network" with doctors and other medical personnel,
- should possess program development skills,
- must be able to educate community people in social rehabilitation,
- must be able to establish prevention programs,
- provide counselling and follow-up,
- conduct family awareness and therapy programs,
- assist the community to develop self-awareness and self-support programs,
- possess the ability to share knowledge gained through experience,
- make home visits,
- have a thorough knowledge of Indian traditions and culture.

The extensiveness of the list of characteristics generated by the Indian mental health study attests to the magnitude of the problems in Indian communities. It also attests to the complexity of skills required of those in the primary health care field. These skills range from the analytical and ideational through to the practical and from there to the deeply personal. They require that a person be open-minded, flexible and adaptable in order to be contextually relevant in working with native communities. Implicit in this is the strength of the willow which yields to the forces of nature yet remains steadfast, as opposed to the mighty oak which in failing to bend falls.

International research in primary health care reveals that it is "within the context of lifestyles that adherence to certain health practices becomes truly meaningful (Hygie, 1984b, p. 55)." If the objective of health promotion and of devolution is to improve the quality of life of native peoples, it is necessary that curriculum developers examine Indian lifestyles not only to develop a coherent body of knowledge for post-secondary education in health promotion, but also for those lifestyle elements which will instill a desire for and love of learning in Indians. For education to be effective it must go beyond mere schooling so that people are free to learn from life and the situations it presents. This may seem like a rather idealistic viewpoint, but it is not. For native people to be effective in finding and defining self-determination,

they must have the will to negotiate a course objectively and reasonably through a welter of legislation, historical precedents, and established, perhaps dysfunctional, practices. This kind of will is nurtured by knowledge tempered with experience as well as by a heart-felt desire for change. Knowledge of Indian culture and lifestyles can help curriculum developers discern the factors which make for continuity and change in Indian life and incorporate awareness of these factors in the design for educating native students in health promotion.

The circle, which is used in the medicine wheel symbolism of native peoples, is a symbol of both change and continuity for the end is also the beginning. The learning of one lesson is the beginning of another. Understanding Indian culture is both the beginning and the end process of curriculum development in health promotion at the post-secondary level. Not only is knowledge of this culture necessary for relevant curriculum, it is also central to the process of effective practice by program graduates. Therefore, the end is also the beginning. In terms of adult education, Coady (1939), author of Masters of Their Own Destiny, explains this concept concisely: "The ultimate objective acts as a motivator. This philosophy not only gives us our right direction but our right beginning as well, while it also serves as a co-ordinator of all our acts and supplies us with our dynamics (p. 114)."

Chapter 5

Recommendations for Planning

Introduction

To this point the author has endeavoured not to prescribe. This was done amid mounting evidence that Indians view education as fundamental to native peoples ability to shape their present and their future. The Indian Mental Health Research Formulation (1985) canvassed 57 Indian communities in Manitoba. From this survey a list was prepared of 50 training programs regarded by Indian communities as important. "Seventy-six percent of the suggested programs [are] clearly related to community and personal mental health (FNC et al., 1985, p.49)." An additional list of 34 prevention programs in the health and social spheres was generated also by the mental health study. Topics on this list range from self-help groups to economic development to family counselling and provide evidence of the great need for improvement in Indian communal life.

In recommending action, the Indian Mental Health Research Formulation (1985) states:

> Indian political organizations, tribal and band councils should be constantly aware in their budgeting and planning of the value of the programs for training and prevention ... presented by the people and listed in the body of this report. The long-term value of these endeavours in improving the mental health, the physical health, and the over-all strength of their communities should take precedent over many short-term goals which may be irrelevant in an unhappy and unhealth community (p. 56).

Therefore, with this spirit in mind the following recommendations are offered.

Recommendations

I. Steering Committee

Evidence has been presented which affirms that it is essential to the success of a post-secondary program in health promotion that it be culturally relevant to Canada's native peoples. Therefore, the first recommendation is for a Steering Committee composed of members of both regional and national native organizations as well as individiuals with expertise in the areas of health, education, social development, curriculum development, and program administration. Clearly, if the objective is for cultural relevance in programming, then the composition of such a Steering Committee must be weighted in favour of Indian representation. The size of the committee may vary from 10 to 20 members. To facilitate the smooth action of the Steering Committee, the first meeting of the committee should establish procedural guidelines possibly including the concept of a quorum. It is suggested that the role of the Steering Committee encompass:

1) defining the parameters of the health promotion curriculum including the delineation of areas of competency for practice and possible program streams;
2) establishing appropriate objectives and timelines to ensure that the efforts of committee members lead to specific goals;
3) acting as a reality check on the cultural relevance of program philosphy, content and methodology by reviewing the work of the

Steering Committee with the agencies or communities the committee members represent;

4) having committee members, when and where appropriate, chair ad hoc committees struck by the Steering Committee to formulate content or to resolve problems;

5) supervising the progress of paid staff towards the accomplishment of the objectives established by the Steering Committee.

II. Staffing for Curriculum Development

To ensure that progress towards the goal of developing a post-secondary level curriculum in the field of health promotion is continuous, it is important that personnel be hired to support the work of the Steering Committee and to carry forward the work of curriculum development in concert with or on behlaf of the Steering Committee. Persons hired for this project should have expertise, developed and/or demonstrated within the context of native culture, in the areas of education, community development, health education, administration and curriculum development. It is suggested that personnel be hired on a contract for a period of 3 to 4 years. A recommended complement for the curriculum development team is three curriculum developers and one clerical support person. One of the curriculum developers will be assigned the responsibility of coordinator reporting to the Steering Committee.

III. Program Site

For the purpose of creating economies of scale, it is recommended that one site be selected for this program. Winnipeg is suggested as the site for program development and delivery for the following reasons:

1) Winnipeg is located at the centre of Canada and is readily accessible by most conventional means of transportation.

2) A multicultural urban centre such as Winnipeg, with its array of agencies and facilities, provides a good setting for teaching native students the skills required to create an appropriate interface between Indian culture and that of the dominant Euro-Canadian society. Students cannot learn these skills theoretically on a reserve. These skills are the hard-won prize of those native students who dare to participate in the tough arena of public practice and of those Indians who have the courage to champion their people's cause.

3) Winnipeg has a rich resource in people. Organizations such as New Careers, First Nations Confederacy, Manitoba Indian Education Association, and Medical Services Branch - Manitoba Region, to name just a few, have qualified individuals available to participate in or to act as a resource for the work of the Steering Committee. Fortunately, because Manitoba has been active in trying to overcome the educational barriers faced by native peoples, many of these qualified people are Indians who

can bring a wealth of experience and insight to the development of the health promotion program.

4) The Post-Secondary Career Development (PSCD) Branch of Manitoba Education has an established record of success in the area of post-secondary education of native peoples and has the experience and the expertise to coordinate the development and delivery of a baccalaureate program in health promotion for native peoples.

5) The University of Manitoba, located in Winnipeg, is one of the few degree-granting institutions which has recognized the significance of culture in education. This university has a Master's level program in cross-cultural education with many human and material resources which could aid the work of the Health Promotion Steering Committee.

IV. Format

It is recommended that the health promotion program be a four year degree program which integrates upgrading and student support services. In considering the subject of program format a number of topics need careful consideration. These include:

1. Support Services

For program success an integrated package of student supports is recommended. Included in this package should be financial aid, tutorial services, personal and family counselling, and relocation

and home adjustment services. It must be remembered that students selected to participate in this program may be coming from a rural or an isolated community to a large urban centre. In normal circumstances this adjustment would be significant enough were it not compounded by the fact that these students are Indians who, in addition to experiencing the dislocation of moving, are also undergoing culture shock. As anyone who has travelled to another country realizes, culture shock is very real and creates considerable tension even in a fairly cosmopolitan person. Therefore, an active approach is recommended. It is not enough that services be available. Students must be taught how to use these services both in the academic milieu and in the community.

It is reasonable to assume that native students will need help in locating affordable housing, finding daycare services for children, identifying a doctor and dentist, shopping for furnishings, as well as in selecting courses or using library services. Program staff must be conversant with a range of support services strategies and resources as well as be continually cognizant of the cultural factors which effect native students' learning and ability to succeed in an urban, academic setting. Program staff must be more than counsellors or tutors. They must be champions, willing and able to undertake the necessary effort to ensure that native students in the health promotion program succeed. However, the role of these champions is a muted one. Native students must be empowered by the

counselling process. This means that the primary function of counselling and other support services is to help native students to act on their own. It is to make them champions in their own right.

2) Student Selection

For the health promotion program to succeed, students must be selected who have the ability, understanding, and personal characteristics required by this field of study. It is suggested that an active recruitment and selection strategy such as that used by PSCD or by the INMED (Indians Into Medicine) program at the University of North Dakota be employed. Such an approach would ensure that students are assessed for their academic potential, are oriented fully to the demands of practice in health promotion as well as to the requirements of the education program, are free of debilitating problems such as active alcoholism, and are aware of and committed to undertaking the range of action necessary to participate in post-secondary education.

Allowing students into the program on a first-come, first-served basis, while egalitarian, is not effective. It must be remembered that the dual themes of health promotion are enpowerment and self-determination. This requires people who have the capacity to be leaders and, most importantly, to be leaders by virtue of their own merit, not by virtue of political or familial fiat.

3) Remediation

As mentioned in Chapters 1 and 4, native students typically

require academic remediation in the areas of language arts, science, and mathematics in order to undertake post-secondary education. The exact nature of the remediation required by students will depend upon the content selected by the Steering Committee as appropriate to the practice of health promotion in native communities and the emphasis created to highlight aspects of culture significant to Indians. Consequently, recommendations for remediation will be restricted to process rather than content.

Because there is no clear evidence that upgrading prior to entry into the regular academic stream promotes academic success (Blanc et al., 1983), it is suggested that an integration strategy be employed. By integrating upgrading with regular coursework, program relevance is maintained. Students are less likely to forget the goal of their education and the need for remedial work if they are engaged in working towards their goal.

To accomplish remediation and normal coursework within a realistic time frame for students, it is recommended that the academic year be twelve months. Eleven of the twelve months can be used for academic purposes. The twelfth month can be used as both an academic break and as an opportunity for students to engage in work experience or to undertake practica in order to supplement their academic skills. It also gives program staff some flexibility in arranging tutorials or special supports, academic or otherwise, for students experiencing particular difficulties.

4) Educational Approach

It is noteworthy that community colleges have a tradition of creating accessibility to post-secondary education for those to whom that door often has been closed. Dennison and Gallagher (1986), authors of Canada's Community Colleges: A Critical Analysis, review the efforts of Canada's community colleges to increase accessibility through curriculum innovation. They note too that the "expansion of programming was not for its own sake, but quite deliberately to make public colleges more inviting to more citizens, to give educational opportunity ... to adults who wished to continue their education but who previously had very limited opportunity beyond that provided as part of the compulsory school systems within Canada (Dennison and Gallagher, 1986, p. 162)."

In Winnipeg, Red River Community College (RRCC) has been part of this movement towards improving educational access. Lee (1983), in her study for the Frontier School Division of Manitoba Education, comments: "... it is interesting to note that of the institutions seriously considered or attended by [native students], Red River Community College was most often cited (p. 11)."

Since it was recommended previously that post-secondary education in health promotion for native peoples be at the baccalaureate level, it is suggested that responsibility for delivering the health promotion program be assigned jointly to RRCC and the University of Manitoba. Precedents for such joint effort have been established in the area of teacher education. This

approach capitalizes on Manitoba native students' interest in RRCC and RRCC's experience in the development and delivery of integrated programming. It also takes advantage of the University of Manitoba's resources and expertise in the areas of health education, cross-cultural education, and education administration. Officials in both institutions were approached at the inception of this practicum and expressed interest in participating in this project.

V. Content

To avoid prejudicing the thinking of any Steering Committee assembled to develop the health promotion program, specific courses in this or related fields will not be included. Needless to say, given the information outlined in Chapter 4, many such courses do exist in Canada and the United States. These can be readily accessed by committee members if needed. However, the intent here is to develop a program which is culturally relevant to native peoples and which will give graduates the knowledge and skills necessary to work with native communities for their own development and on behalf of native communities within the larger Canadian society. Therefore, careful scrutiny of both content and process is very important. Simply borrowing a program developed elsewhere for another social milieu will lead inevitably to failure.

To avoid creating an academic ghetto it is absolutely vital that the health promotion program for native peoples meet all standards for academic rigor. While this program may be designed for the special circumstances confronting native peoples, it must deal with

the universal as well as the particular in an educationally sound manner. The resultant program should appeal as much to any person wanting a quality education in health promotion as it does to native peoples.

A fairly neutral point of entry for the examination of educational content and process can be found in the work of the various role delineation studies in health education mentioned in Chapter 4. These studies list a number of knowledge and skill competencies required by an entry-level health educator. Indications from these studies are that graduates require a core of knowledge and skills. Knowledge in the area of health education is found usually in the health sciences, behavioural sciences and health education. Skills typically are located in the domains of assessment, planning, coordination, administration, service delivery, evaluation, organizational development, and continuing education.

An important caveat to remember here is that no educational document, even a list of descriptors such as knowlege and skill competencies, is value free. While the competencies outlined by the role delineation projects can provide a starting point for discussion and action, they must be supplemented by a careful examination of the needs, goals, aspirations and lifestyles of native peoples. For example, an area of significance for native peoples is legislation; federal legislation such as the Indian Act as well as federal-provincial legislation in the areas of health care and education. Being able to analyze and interpret legislation as well

as to negotioate new legislation or amendments to existing legislation is essential to the progress of Indian peoples. Yet, competencies in this area will not be found in any Canadian or American role dilineation study in health education.

With this caveat firmly in mind, there follows a sample of health education competencies. The purpose here is to create a sense of the interrelatedness of areas of responsibility in the workplace and the essential connection between knowledge and skill. As reported by the United States Bureau of Health Education (1980), the role of an entry-level health educator encompasses 7 areas of responsibility:

- communicating health and health education needs, concerns and resources
- determining the appropriate focus for health education
- planning the appropriate focus for health education
- implementing planned health education programs
- evaluating health education programs
- co-ordinating selected health education activities
- acting as a resource for health and health education

(U.S. Bureau of Health Education, 1980, p. 2).

The sample of competencies selected for inclusion relates to responsibility two and is as follows:

> The entry-level health educator, working with individuals, groups and organizations, is responsible for:
> DETERMINING THE APPROPRIATE FOCUS FOR HEALTH EDUCATION (10%).
> The entry-level health educator, working with individuals, groups and organizations, is responsible for:

Function: A. Collecting information about populations of interest. (48%)

Skill: 1. The health educator must be able to gather data about health-related behaviors, needs and interests.

Knowledge: The health educator must be able to:

a. identify determinants related to specific health behaviors (e.g., genetic factors, fear, ignorance, perceptions, social influences).

b. list sources to determine health needs and interests (e.g., epidemiological data, public expressions, interview with school and health officials and those affected).

c. summarize data expressed in different forms (e.g., written reports, charts, graphs).

Skill: 2. The health educator must be able to identify social, cultural, environmental, organizational, and growth development factors that affect health behavior, needs and interests.

Knowledge: The health educator must be able to:

a. describe social, cultural, and environmental factors which affect health behavior, needs and interests (e.g., belief systems, orientation in society, medical geography).

b. list methods to study social, cultural and environmental factors to determine impact on behavior of a given population (e.g., community survey, sociometric study, participant-observer, epidemiology).

c. identify growth and development patterns of various age groups (e.g., children, adolescents, older adults).

d. describe the social structure of the population to be served (e.g., ethnicity, socio-economic status, political make-up).

Skill: 3. The health educator must be able to identify available health-related resources.

Knowledge: The health educator must be able to:

a. describe health-related resources within a given area (e.g. hospitals, schools, public health departments, voluntary health associations).

b. match resources with a given population to resolve a health concern (e.g., define a community of solution, evaluate population in need and efficacy of resources).

The entry-level health educator, working with individuals, groups and organizations, is responsible for:

Function: B. Analyzing information to determine areas of need. (52%)

Activity: Selecting potential areas for health education.

Skill: 1. The health educator must be able to select potential areas for health education.

Knowledge: The health educator is able to:

a. list elements essential for a successful health education program. (e.g., fiscal and administrative support, personnel, program design).

b. recognize situational influences in priority selection (e.g., timing, other programs, interested parties, availablility of resources).

c. describe the process of priority selection (e.g., determining criteria, recognizing environmental factors, analysis of available data, weighing alternatives) (U.S. Bureau of Health Education, 1980, p. 12).

A fuller listing of competencies derived from role dilineation studies in health education is found in Appendices 4, 5, and 7.

VI. Budget

Any budget developed at this stage of program planning must be regarded as tentative. A post-secondary program in health promotion for native peoples is a new concept and full development of this program will require considerable effort if it is to be as culturally

relevant as proposed. Consequently, the budget presented here is tentative. The work of the Steering Committee will aid in the definition of program requirements and subsequent programming decisions will make it possible to determine costs more precisely.

The budget which follows covers a period of five fiscal years. It represents follow-through on the activity of the Steering Committee and the costs related to a student intake of 20. It is possible to intake another 15 to 20 students in each year following program initiation. However, this budget does not incorporate these costs.

Each budget heading represents a category rather than discreet items. Program development includes the costs of hired staff for curriculum development as well as costs for the expenses of Steering Committee members. Student support covers a wide range of items such as student allowances, rental subsidies, transportation allowances, daycare expenses, medical, dental and optical care, etc. Academic support subsumes tuition fees, student books and supplies, instructional materials, etc. Student selection includes travel, rentals, and other costs incurred by student selection procedures. Student relocation covers the expenses incurred by students selected for the program and their dependents in relocating to the program site and establishing themselves in new surroundings. Administrative support includes all costs involved in the rental and maintenance of program offices and the support of project staff.

Salaries covers all salaries for program staff such as administrators, tutors, counsellors, secretaries, and programming experts who may be needed periodically. Increases in initial budget estimates are calculated at the rate of 5% inflation for costs related to program development and 3% for all other items. The reason for this differential relates to the travel undertaken by Steering Committee members, some of whom may represent national organizations.

By the end of fiscal year 1991/92 the curriculum development role of the Steering Committee and the staff hired to aid in this function should be complete. The contracts of hired staff will end with a resultant overall reduction in the program budget. The role of the Steering Committee should continue to ensure that the cultural integrity of the program is maintained, to check on the effectiveness of program implementation, and to maintain continual program evaluation. (See Figure 5.1 for budget.)

Conclusion

A few very strong themes run through this practicum. The theme of health promotion is empowerment. The theme of devolution is self-determination. The theme of education in health promotion for native peoples is cultural relevance. The merging of these three themes in an educational program designed to be academically rigorous and culturally coherent for native peoples will create a solid foundation for positive growth and development in Indian communities.

Figure 5.1: Five Year Development Budget

	87/88	88/89	89/90	90/91	91/92
Program Development	$ 210,000	$ 220,000	$ 230,000	$ 240,000	$ 50,000
Student Support		1,004,000	1,071,200	1,103,336	1,136,436
Academic Support		160,000	164,800	169,744	174,840
Student Selection		8,000	8,240	8,488	8,742
Student Relocation		8,000	8,240	8,488	8,742
Administrative Support		80,000	82,400	84,872	87,420
Salaries		304,000	313,120	322,514	332,189
Total	$ 210,000	$1,820,000	$1,878,000	$1,937,442	$1,798,369

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LIST OF APPENDICES

Appendix 1

MEAN PROBLEM AREA RATINGS PER TRIBAL COUNCILS AND UNAFFILIATED BANDS

TRIBAL COUNCIL/ UNAFFILIATED BANDS	ALCOHOL ABUSE	SOLVENT ABUSE	DEPRESSION	SUICIDE	ATTEMPTED SUICIDE	PSYCHOSIS	ANXIETY	CHILD ABUSE	SPOUSE ABUSE	TRUANCY	FETAL ALCOHOL SYNDROME	VIOLENCE
Keewatin Tribal Council	3.75	2.29	3.5	1.42	2.5	1.42	3.75	2.33	1.33	2.42	.17	3.42
Norway House	3.0	3.0	3.0	1.0	1.0	1.0	4.0	2.0	3.0	2.0	0	4.0
Island Lake Tribal Council	3.13	0.75	3.75	0.25	1.25	0.75	4.0	2.0	2.13	1.0	0	3.25
Swampy Cree Tribal Council	3.86	2.0	3.86	1.0	1.43	0.86	4.14	1.71	1.71	2.43	0	3.71
Dakota Ojibway Tribal Council	3.50	2.63	3.25	1.13	2.88	1.0	4.38	2.19	1.25	3.50	1.13	2.5
West Region Tribal Council	3.89	0.89	3.78	0	2.67	1.4	4.22	1.56	1.67	1.33	0.67	2.0
Southeast Resource Development Council	3.81	1.56	3.5	1.25	2.75	0.75	3.25	1.94	2.25	2.63	1.25	3.13
Dakota Tipi	3.0	2.0	3.0	2.0	2.0	2.0	2.0	2.0	3.0	2.0	2.0	4.0
Interlake Reserves Tribal Council	4.0	0.71	2.86	2.86	0.71	2.14	2.0	1.79	1.29	2.14	.43	1.43
Fort Alexander	5.0	2.0	3.0	4.0	5.0	4.0	4.0	3.0	4.0	4.0	3.0	3.0
TOTALS:	3.77	1.76	3.33	1.43	2.24	1.49	3.75	2.17	1.83	2.38	.74	2.94

LEGEND: 0,1 : Not a problem, minor
2 : Low average, problem but minor
3 : High average, serious cause of stress
4,5 : Major problem, threatening stability of community

SOURCE: Indian Mental Health Research Formulation: Final Report (draft), by First Nations Confederacy, Brotherhood of Indian Nations, and Manitoba Keewatinowi Okimanak, 1985, p. 32a.

Appendix 2

Solemn Declaration

We the Indigenous Peoples of the world, united in this corner of our Mother the Earth in a great assembly of men of wisdom, declare to all nations:

We glory in our proud past:
when the earth was our nurturing mother,
when the night sky formed our common roof,
when Sun and Moon were our parents,
when all were brothers and sisters,
when our great civilizations grew under the sun,
when our chiefs and elders were great leaders,
when justice ruled the Law and its execution.

Then other peoples arrived:
thirsting for blood, for gold, for land and all its wealth,
carrying the cross and the sword, one in each hand,
without knowing or waiting to learn the ways of our worlds,
they considered us to be lower than the animals,
they stole our lands from us and took us from our lands,
they made slaves of the Sons of the sun.

However, they have never been able to eliminate us,
nor to erase our memories of what we were,
because we are the culture of the earth and the sky,
we are of ancient descent and we are millions,
and although our whole universe may be ravaged,
our people will live on
for longer than even the kingdom of death.

Now, we come from the four corners of the earth,
we protest before the concert of nations
that, "we are the Indigenous Peoples, we who
have a consciousness of culture and peoplehood
on the edge of each country's borders and
marginal to each country's citizenship."

And rising up after centuries of oppression,
evoking the greatness of our ancestors,
in the memory of our Indigenous martyrs,
and in homage to the counsel of our wise elders:

We vow to control again our own destiny and
recover our complete humanity and
pride in being Indigenous People.

SOURCE: The Formation of the World Council of Indigenous Peoples, by D. Sanders, 1977, p. 17.

Appendix 3

First Principles

1. Wholeness. All things are interrelated. This connectedness derives from the reality that everything is a part of a single whole which is greater than the sum of its parts. Hence any given phenomenon can only be understood in terms of the wholeness out of which it comes.
2. Change. All of creation is engaged in a process of constant change. There are two general categories of change: development, or integration, and disintegration. Both are necessary and inseparably linked.
3. Process. The course of change generally follows observable patterns which occur in cycles or stages. There is a direction (an implied intentionality) to all change that leads to some outcome which can only be fully understood in relationship to the context within which the process is taking place.
4. All of creation may be understood in terms of two categories of existence: material reality and spiritual reality. These two categories of existence are functionally inseparable. Yet there are distinct laws and principles which govern each dimension.
5. Human beings exist in connection with all other aspects of creation.
6. Human beings are material and spiritual beings.
7. Human beings are in process of becoming (i.e. actualizing potentiality) from conception to eternity. This is true of individuals as well as human collectives such as the family and the community.
8. Human beings have the capacity to create further potentiality through the cumulative effects of learning and culture. Hence human potential may be regarded as infinite.
9. As human beings, we transcend the limitations of mere materiality by virtue of our ability to direct the process of our own becoming.
10. The spiritual dimensions of human development may be understood in terms of four related capacities.
    - First, the capacity to formulate and/or to respond to non-material realities such as dreams, visions, ideals, spiritual teachings, aims, purposes, and theories.
    - Second, the capacity to accept these realities as representations or manifestations of unknown human potential.
    - Third, the capacity to give these non-material realities symbolic expression (through art, mathematics or language).
    - Fourth, the capacity to use this symbolic expression to guide action that is aimed at translating potentiality into actuality.
11. Human spirituality is expressed and developed through the practice of life-preserving, life-enhancing values. (A value may be understood as a patterned use of human energy). These values (we may also call them qualities or virtues) include honoring the Creator, honesty, love, wisdom, justice, courage, respect, courtesy and humility to name only a few. The realization of these values in human affairs is an indispensable component of human development.
12. The esssence of human actualization is the process of coming to know and to love the ultimate unknowns underlying the ordering of the universe. This is an infinite process. It may be expressed by individuals as well as by human collectives.

SOURCE: Four Worlds Development Project - Overview, by M. and J. Bopp, 1984, p. 111.

ROLE SPECIFICATION FOR THE ENTRY-LEVEL HEALTH EDUCATOR

The role specification is divided into two related component parts. The major and specific responsibilities and requisite skills are outlined in the first part, while knowledge essential for skill development is included in the second component.

Regardless of practice setting, seven major responsibilities are common to all entry-level health educators. These seven are termed *areas of responsibility*. Each area of responsibility is comprised of related specific responsibilities called *functions*. Each function requires skills, termed *activities*, in order to be appropriately carried out. Each essential activity is weighted according to its importance to carrying out its related function in specific practice settings: school, community, and medical care.

Acceptable performance of the activities subsumed under each function is dependent upon a foundation of knowledge. Knowledge necessary for performing activities within a function is included in a matrix that matches cognitive elements with functions of the role specification. For purposes of this publication, an inventory of knowledge essential to the role is presented.

Settings	Weights
S = school	3 = crucial
C = community	2 = highly essential
M = medical care	1 = essential

ROLE SPECIFICATION

Working with individuals, groups and organizations, the health educator:

I. ASSESSES THE NEED FOR HEALTH EDUCATION

	S	C	M
A. Identifies health-related data about social and cultural environments, growth and development factors, and needs and interests of defined populations			
1. gathers data about health-related concerns, behaviors, needs and interests	3	3	3
2. gathers data on available health-related resources	3	3	3
3. reviews media sources for health information	3	2	3
4. conducts literature searches	2	1	2
5. uses survey techniques to acquire data	1	2	2
6. attends seminars, symposia, conferences, and other meetings in reference to health concerns	3	2	2
7. maintains a file of frequently used current health information	3	3	3
8. seeks the advice of other professionals	3	3	3

B. Analyzes information to determine areas of need of defined populations			
1. compares information on the health concerns and needs of a population with available services	1	2	2
2. interprets data about the social environment	1	1	1
3. assesses growth and development factors	1	1	1
4. interprets collected data regarding health practices, attitudes and knowledge	2	2	2
5. determines the utility of health education to meet identified needs	3	3	3
6. examines legislative requirements related to program activities	1	1	1
C. Identifies potential targets for educational intervention			
1. determines which of the identified needs and interests of the defined population have the greatest impact upon their health	2	3	3
2. compares health needs and interests with available personal, organizational and material resources	2	3	3
3. evaluates priorities of those affecting and affected by educational programs	2	2	1
4. selects priorities for possible program development	2	2	3

Working with individuals, groups and organizations, the health educator:

II. PLANS HEALTH EDUCATION PROGRAMS

A. Participates in the planning process			
1. communicates identified needs to those involved	3	3	3
2. evaluates the organizational structure of the agency in which the planned program will function	1	1	2
3. identifies budgetary needs to carry out the program	2	1	2
4. acquires ideas and opinions from persons involved with the educational program	2	3	3
5. incorporates acquired ideas and opinions into the planning process	2	3	3
B. Gains support for the program			
1. secures administrative support for program implementation	1	3	3
2. identifies potential political, organizational, financial and human resources for program implementation	3	3	3
3. locates funds to carry out the program	1	1	1
C. Develops program objectives			
1. identifies personal characteristics (knowledge, values and behaviors) that contribute to the individual's educational needs	3	2	3

SOURCE: A. C. Henderson, 1982, p. 16. The Refined and Verified Role for Entry-Level Health Educators, by

2. identifies environmental influences which block or support resolution of educational concerns	2	2	2
3. compares identified needs with available resources	2	2	2
4. establishes a time frame for planning, conducting and evaluating program activities	2	3	3
5. establishes measurable educational objectives for the program	3	3	3
D. Designs educational programs to meet specified objectives			
1. determines a logical scope and sequence for learning experiences	3	3	3
2. selects a variety of educational methods for use in program implementation	3	3	3
3. provides assessment of selected educational methods	3	2	3
4. pilots educational programs to test their value	1	2	2

Working with individuals, groups and organizations, the health educator:

III. COORDINATES PLANNED HEALTH EDUCATION PROGRAMS			
A. Carries out designated administrative activities for the health education program			
1. prepares written and oral reports about one's own or other health education programs for other professionals and decision-makers	1	2	2
2. arranges for physical facilities for health education programs	1	2	2
3. acquires needed educational materials	3	2	3
4. participates in policy planning within the employing organization	1	1	2
5. coordinates the approach, timing, and effort among those involved in program activities	1	2	3
6. uses budgeted funds as allocated to carry out the program	2	1	2
B. Maintains the support of other staff for health education programs			
1. combines health education with other organizational activities or programs	1	2	2
2. promotes cooperation and feedback among personnel related to health education programs	2	3	3
3. promotes health education as a priority within the employing organization	3	3	3
C. Acts as a facilitator			
1. serves as a liaison among individuals, groups and organizations	1	3	3

2. organizes group meetings involving those concerned with health education activities	1	2	3
3. explains the purposes, programs and resources of one's own organization	1	3	3
4. assists individuals and organizations with differing points of view to understand each other and the issues in question	1	1	1
D. Assists other staff and/or volunteers responsible for carrying out health education activities			
1. prepares health education program materials for others to use	1	2	2
2. identifies additional personnel needed to carry out the program	1	2	2
3. trains personnel to carry out health education activities	1	1	1
4. supervises others in conducting health education activities	1	1	1
E. Advocates for health education			
1. prepares written and oral statements for policy-makers (e.g. school superintendents, department heads, legislators)	1	1	1
2. explains legislation and policies affecting health education programs	1	1	1
3. promotes public support for health education through media contacts and appropriate public relations activities	2	2	2
4. articulates the purposes, theory, concepts and processes of health education programs to policy-makers	1	1	1

Working with individuals, groups and organizations, the health educator:

IV. PROVIDES DIRECT HEALTH EDUCATION SERVICES			
A. Employs educational methods designed for a specific audience			
1. uses mass media	2	3	2
2. uses group process skills	3	3	3
3. uses public speaking skills	3	3	3
4. organizes community groups for program support	1	3	2
5. uses instructional media	3	3	2
6. uses peer support groups	2	1	1
7. provides personal health counseling	2	1	1
B. Monitors education activities			
1. coordinates resources	2	2	3

2. assesses program activities in relation to program objectives 3 3 3
3. adjusts program activities to meet changing educational needs 3 3 3

C. Serves as a resource person
1. describes functions and services of community resources 1 2 2
2. provides advice to other professionals 1 2 2
3. explains written, graphic, and verbal data 1 2 2
4. identifies educational resource materials which meet the needs of individuals, groups, and organizations 2 3 3
5. evaluates the applicability of resource materials 3 3 3
6. acquires selected resource materials 3 3 2
7. organizes health education materials for easy access 2 2 2
8. responds to requests for information 3 3 3

Working with individuals, groups and organizations, the health educator:

V. EVALUATES HEALTH EDUCATION

A. Designs plans to access educational methods and achievement of educational objectives
1. specifies measurable indicators of successful educational processes and outcomes 2 3 3
2. defines what will be included in program evaluation 2 2 3
3. selects methods for evaluating programs 2 2 3
4. identifies instruments for data collection 1 1 2
5. determines the type of data useful for demonstrating program effectiveness 1 2 2

B. Implements evaluation plans
1. arranges for facilities, materials, personnel and equipment to carry out evaluation 1 1 2
2. secures the cooperation of those involved with the evaluation 1 1 2
3. collects data for evaluation 1 1 2
4. analyzes collected evaluation data 1 2 2

C. Interprets the results of evaluation
1. assesses the degree to which objectives were achieved 2 2 3
2. assesses the effectiveness of educational methods in achieving objectives 2 2 3
3. reports the processes and results of evaluation 1 2 3
4. recommends strategies for implementing results of evaluation 1 1 3

5. incorporates recommendations into planning, coordination, and direct services 1 2 3

Working with individuals, groups and organizations, the health educator:

VI. PROMOTES ORGANIZATIONAL AND SOCIAL DEVELOPMENT

A. Works with others to modify policies of institutions, agencies and/or groups to more effectively meet identified needs
1. participates in identifying needed policy changes 1 1 1
2. articulates the need for policy change to others 1 1 1
3. organizes support for policy change 1 1 1
4. assists in developing action plans for change 1 1 1
5. provides leadership in effecting needed change 1 1 1

Working with individuals, groups and organizations, the health educator:

VII. CONTINUES TO DEVELOP PROFESSIONALLY

A. Implements career plans
1. identifies career paths in health education 2 2 2
2. assesses additional education and experience necessary for career advancement 1 2 2
3. seeks opportunities in accordance with career plans 1 2 2

B. Improves professional competencies
1. Maintains knowledge about health education through the literature of the field 3 3 3
2. participates in conferences, workshops and continuing education programs 3 3 3
3. assesses strengths and weaknesses in one's own professional skills 3 3 3
4. seeks consultation from other health educators and professionals 3 3 3
5. learns from related professions about other programs, concepts, methods and terminology 3 3 3
6. assesses ways to improve program efforts 3 3 3
7. collaborates with other personnel to maximize health education's contributions to the employing organization 2 3 3

AN INVENTORY OF KNOWLEDGE ESSENTIAL TO ROLE PERFORMANCE

The following inventory presents knowledge essential to each function described in the role specification. There are three basic components of knowledge essential to quality practice:

1.0 Behavioral Science
2.0 Health Sciences
3.0 Health Education

If it may be helpful to the reader to develop a more specific link between each cognitive element and the functions of the role specification, a matrix matching knowledge items and role functions was submitted in the final report to the federal government.[8]

AN INVENTORY OF KNOWLEDGE ESSENTIAL TO ROLE PERFORMANCE

1.0 Behavioral Sciences

1.1 *Administration*
- 1.1.1 decision-making
- 1.1.2 evaluation
- 1.1.3 contracting for services
- 1.1.4 administrative policy development
- 1.1.5 budgeting
- 1.1.6 coordination
- 1.1.7 records and their maintenance
- 1.1.8 team management
- 1.1.9 supervision
- 1.1.10 priority setting
- 1.1.11 systems analysis
- 1.1.12 problem-solving
- 1.1.13 personnel management and needs analysis
- 1.1.14 proposal preparation
- 1.1.15 administrative planning
- 1.1.16 third party negotiation and arbitration
- 1.1.17 program reporting
- 1.1.18 group process for organizations
- 1.1.19 scheduling
- 1.1.20 public relations
- 1.1.21 models of authority

1.2 *Anthropology*
- 1.2.1 cultural aspects of health and disease
- 1.2.2 concepts and components of communities

- 1.2.3 beliefs, practices and traditional systems
- 1.2.4 health as a component of society
- 1.2.5 law, morality and customs in society
- 1.2.6 perceptions of the world and self

1.3 *Communications*
- 1.3.1 objectives of communications
- 1.3.2 formal and informal communications
- 1.3.3 listening techniques
- 1.3.4 mass media
- 1.3.5 communications theories
- 1.3.6 verbal and non-verbal communications
- 1.3.7 perception and deprivation of sensory input
- 1.3.8 characteristics of the communicator and communicant
- 1.3.9 barriers to communications
- 1.3.10 use of feedback
- 1.3.11 communications networks
- 1.3.12 use of language
- 1.3.13 interviewing
- 1.3.14 computer usage
- 1.3.15 psychological influence

1.4 *Economics*
- 1.4.1 cost-benefit analysis
- 1.4.2 cost-effectiveness analysis
- 1.4.3 economic support systems
- 1.4.4 economic characteristics of parts of the social system
- 1.4.5 economics of health and medical care
- 1.4.6 economic influences on personal behavior

1.5 *Education*
- 1.5.1 educational materials and their development
- 1.5.2 philosophies, missions and goals of education
- 1.5.3 development of measurable objectives
- 1.5.4 values clarification
- 1.5.5 educational program planning theory, practices and trends
- 1.5.6 instructional media development and uses
- 1.5.7 information dissemination
- 1.5.8 simulation and games in education
- 1.5.9 educational counseling
- 1.5.10 learning theories
- 1.5.11 role of education in the social system
- 1.5.12 educational strategies
- 1.5.13 implementation of educational programs

SOURCE: The Refined and Verified Role for Entry-Level Health Educators, p.22.

1.5.14 educational evaluation
1.5.15 educational training
1.5.16 andragogy (adult education)
1.5.17 pedagogy
1.5.18 conditions for learning
1.5.19 community organization in education
1.5.20 group process applied to education
1.5.21 educational recordkeeping
1.5.22 decision-making
1.5.23 problem-solving
1.5.24 coordinating educational programs
1.5.25 teaching styles
1.5.26 audio-visual aids and their mechanical use
1.5.27 educational statistics
1.5.28 educational research
1.5.29 risk-taking (as a method)
1.5.30 self-discovery
1.5.31 inquiry (as a method)
1.5.32 educational psychology
1.5.33 educational needs and interests determination
1.5.34 educational settings and personnel
1.5.35 experiential learning
1.5.36 behavioral conditioning and learning

1.6 *Political Science*
1.6.1 legal rights
1.6.2 methods of advocacy
1.6.3 policy formulation, regulations and law making
1.6.4 political systems
1.6.5 political decision-making
1.6.6 political theory
1.6.7 public administration
1.6.8 regulation of professions

1.7 *Psychology*
1.7.1 determinants of behavior
1.7.2 psychological needs
1.7.3 psychological aspects of health
1.7.4 motivation and beliefs
1.7.5 psychological problems (disorders)
1.7.6 mental health characteristics
1.7.7 psychological aspects of growth and development
1.7.8 behavior change theories
1.7.9 personality

1.8 *Social Psychology*
1.8.1 organization and conduct of meetings
1.8.2 group dynamics and processes
1.8.3 interpersonal relationships
1.8.4 resolution of conflict
1.8.5 attainment of cooperation
1.8.6 community organization
1.8.7 team building
1.8.8 participative decision-making
1.8.9 organizational behavior theory
1.8.10 role theory
1.8.11 evaluation
1.8.12 risk-taking
1.8.13 counseling
1.8.14 concepts of change processes and agents
1.8.15 symbolic interaction
1.8.16 social learning
1.8.17 socialization and perception
1.8.18 social motivation
1.8.19 development of values, beliefs, attitudes
1.8.20 field theory
1.8.21 health belief model
1.8.22 social control
1.8.23 organizational change
1.8.24 consultation
1.8.25 diffusion and adoption

1.9 *Sociology*
1.9.1 social aspects of health
1.9.2 community structure
1.9.3 concepts of community
1.9.4 social support systems
1.9.5 social change theory
1.9.6 social aspects of growth and development
1.9.7 community analysis
1.9.8 analysis of power structures
1.9.9 community development
1.9.10 social stratification
1.9.11 systems theory
1.9.12 structure of social services
1.9.13 structural aspects of social problems
1.9.14 medical sociology
1.9.15 process of socialization
1.9.16 social learning
1.9.17 planned social change

2.0 Health Sciences

2.1 *Public Health*
- 2.1.1 administration and organization
- 2.1.2 environment and sanitation
- 2.1.3 epidemiology
- 2.1.4 biostatistics
- 2.1.5 personnel and professions
- 2.1.6 definition and principles
- 2.1.7 history
- 2.1.8 educational functions

2.2 *Medical Care*
- 2.2.1 definition and principles
- 2.2.2 terminology
- 2.2.3 organization
- 2.2.4 allopathic, osteopathic, homeopathic, chiropractic
- 2.2.5 preventive medicine
- 2.2.6 personnel and professions
- 2.2.7 allied health personnel and occupation
- 2.2.8 history
- 2.2.9 educational functions

2.3 *Nursing*
- 2.3.1 definition and principles
- 2.3.2 organization
- 2.3.3 personnel and professions
- 2.3.4 history
- 2.3.5 educational functions

2.4 *Dentistry*
- 2.4.1 definition and principles
- 2.4.2 organization
- 2.4.3 personnel and professions
- 2.4.4 history
- 2.4.5 educational functions

2.5 *Other Health Sciences*
- 2.5.1 veterinary medicine
- 2.5.2 podiatry
- 2.5.3 optometry
- 2.5.4 educational functions
- 2.5.5 organization

3.0 Health Education

3.1 *History of Health Education as a Discipline and Profession*
- 3.1.1 origins in other fields
- 3.1.2 professional associations
- 3.1.3 contributions of research

3.2 *Principles of Health Education*
- 3.2.1 beliefs
- 3.2.2 purposes
- 3.2.3 philosophies
- 3.2.4 theories of health and health education
- 3.2.5 professional ethics

3.3 *Health Education Processes Applied to Health Concerns*
- 3.3.1 environmental health
- 3.3.2 communicable and non-communicable diseases
- 3.3.3 human sexuality
- 3.3.4 nutrition
- 3.3.5 consumer health
- 3.3.6 accident prevention
- 3.3.7 personal health
- 3.3.8 community health
- 3.3.9 mental health
- 3.3.10 substance abuse

3.4 *Educational Methods Applied to Health Education Activities*
- 3.4.1 applications of learning theory
- 3.4.2 instructional
- 3.4.3 group processes
- 3.4.4 community organization
- 3.4.5 consultation
- 3.4.6 training
- 3.4.7 counseling

3.5 *Educational Resources Applied to Health Education Activities*
- 3.5.1 literature of health education
- 3.5.2 literature of related disciplines
- 3.5.3 health information
- 3.5.4 instructional and mass media
- 3.5.5 community agencies and organizations
- 3.5.6 health education program designs
- 3.5.7 laws and regulations and policies governing health education

3.6 *Application of Health Education in Practice Settings*
- 3.6.1 business/industry/labor
- 3.6.2 community agencies and organizations
- 3.6.3 medical care organizations
- 3.6.4 school settings

3.7 *Current Issues in Health Education*
- 3.7.1 health education and health promotion
- 3.7.2 behavior change and accountability
- 3.7.3 comprehensive school health education
- 3.7.4 health education theory
- 3.7.5 evolution of health education as a profession
- 3.7.6 need for health education and need for health educators
- 3.7.7 accountability

Appendix 6

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Appendix 7

Specification of the Role of the Entry-Level Health Educator

Area of Responsibility I:

The entry-level health educator, working with individuals, groups and organizations is responsible for:

COMMUNICATING HEALTH AND HEALTH EDUCATION NEEDS, CONCERNS, AND RESOURCES (19%) [1]

The entry-level health educator, working with individuals, groups and organizations is responsible for:

Function: A. Providing information regarding health and health education. (25%) [2]

Skill: 1. The health educator must be able to use mass media to provide health information.

Knowledge: The health educator must be able to:
- a. identify the steps necessary to prepare materials for dissemination through the media (e.g., identifying the target for the information, proposing various media techniques, selecting the most appropriate method, developing the materials).
- b. describe the strengths and weaknesses of various mass media methods for providing health information (e.g., lack of control over the message, selected perception, reaching large groups, attracting interest).
- c. identify media most appropriate for disseminating specific health information to a specific population (e.g., smoking and adolescents, Medicare benefits and the elderly, nutritional information and teenage mothers).

Skill: 2. The health educator is able to use group process skills to provide information.

Knowledge: The health educator must be able to:
- a. list elements of a successful group discussion (e.g., active listening, member involvement, progress toward an objective).
- b. describe various group process techniques (e.g., nominal group, T-group, communities of solution, community organization).
- c. distinguish appropriate group process techniques for providing information on a health topic to a particular group from those available (e.g., fluoridation to a civic club, nutrition to a patient group, wellness concepts to elementary school children).

Skill: 3. The health educator must be able to use public speaking skills to present health information.

Knowledge: The health educator must be able to:
- a. identify oral presentation skills (e.g., speaking clearly, organize presentation, selecting the presentation style to match the audience).
- b. describe oral presentation techniques to be used to present specific information to a specified group (e.g., lecture, lecture-discussion, group process).
- c. explain how media can assist oral presentations (e.g., overhead projector, film projector, audio or video cassette).

[1] Weighted percentage value in comparison to all other areas of responsibility.

[2] Weighted percentage value relative to all other functions in this area of responsibility.

SOURCE: Health Education and Credentialing : The Role Delineation Project, by U. S. Bureau of Health Education, 1980, July, p.7.

Skill: 4. The health educator must be able to establish opportunities to provide health information.

Knowledge: The health educator must be able to:
a. identify means to present health information to various groups (e.g., contacting program planners, initiating programs through professional groups, responding to requests).
b. describe the planning of a presentation tailored to a particular group (e.g., establishing objectives, determining characteristics of the audience, selecting presentation methods).
c. list steps essential to establishing opportunities to present information (e.g., identifying established and emerging groups, matching information with group needs and interests, recognizing the importance of timing and opportunities).

The entry-level health educator, working with individuals, groups and organizations, is responsible for:

Function: B. Interpreting health information. (17%)

Skill: 1. The health educator must be able to explain written, graphic and verbal data.

Knowledge: The health educator must be able to:
a. list the various methods and uses of data collection techniques (e.g., counts, observations, averages, differences).
b. recognize the strengths and weaknesses of data presentation (e.g., anecdotes, misleading graphs, demonstrating relationships).
c. describe the process of selecting data presentation format for presentation to specific audiences (e.g., knowledge of audience characteristics, assessment of the complexities of the data, analysis of session purposes with regard to needed and available data).
d. identify probable health consequences of selected behaviors for various audiences (e.g., smoking and eating habits, exercising, self-care procedures).

Skill: 2. The health educator must be able to predict outcomes of alternative health education strategies on behavior.

Knowledge: The health educator must be able to:
a. describe concepts of human behavior (e.g., psychological, sociological, anthropological, educational).
b. identify educational components of health concerns of interest (e.g., promoting health, preventing disease, minimizing impact of disease).
c. describe probable health education outcomes given a particular health concern, environment for the program, and resources available (e.g., information on smoking through mass media, support of health promotion by employers, videotapes in clinic waiting room).

Skill: 3. The health educator must be able to explain the purposes and resources of the organization employing the health educator.

Knowledge: The health educator must be able to:
a. identify the purposes, objectives, and resources of his/her employer (e.g., statements of goals, legal status, statements of position on issues, history of the organization, features of its activities).
b. describe methods and materials used to inform selected audiences (e.g., professional meetings, pamphlets, films, annual reports, civic club meetings).

Skill: 4. The health educator must be able to articulate the purpose, theory, concepts and processes of health education.

Knowledge: The health educator must be able to:
a. define health education as a discipline and professional field (e.g., body of knowledge, standards for practice, orientation).
b. identify the purpose of health education (e.g., facilitate informed decision-making on health matters).
c. describe theory and concepts of health education (e.g., health belief model, grounded theory).
d. list the various processes used by health educators (e.g., individual counseling, group facilitation, community organization, values clarification, classroom instruction).
e. describe how health education articulates with other health activities (e.g., health education and wellness concepts, health education and disease prevention, health education and health promotion).

Skill: 5. The health educator must be able to describe functions and services of community resources.

Knowledge: The health educator must be able to:
a. list official, voluntary and proprietary groups, agencies and organizations on the local, state and national scene (e.g., schools, public health departments, American Heart Association).
b. state the purposes, functions and resources of various agencies (e.g., education, service and research, school-based functions, population-group functions, personnel and material resources).

The entry-level health educator, working with individuals, groups and organizations, is responsible for:

Function: C. Facilitating communication. (16%)

Skill: 1. The health educator must be able to articulate the viewpoint(s) of others.

Knowledge: The health educator must be able to:
a. describe the process of acquiring others' views (e.g., personal contact, reading literature, asking questions).
b. define "frame of reference" (e.g., knowledge, values, perspective).
c. relate views of one audience to others (e.g., translates culture-bound items, assesses perceptions of audience, recognizes need for exploration).

Skill: 2. The health educator must be able to assist persons with differing viewpoints, acting individually or collectively, to understand issues in question.

Knowledge: The health educator must be able to:
a. describe the characteristics of active listening (e.g., attending to the speaker, discerning the direction of the communication, matching content with own perspectives).
b. list principles of group dynamics applicable to clarifying issues (e.g., leadership roles, blocking roles, facilitating roles).
c. identify elements of the resolution of conflict process (e.g., clarifying misunderstandings, describing points of disagreement, seeking alternatives to disagreements).

Skill: 3. The health educator must be able to act as a liaison among and between relevant parties.

Knowledge: The health educator must be able to:
a. describe a variety of communications methods (e.g., formal and informal, selected and systematic, verbal and non-verbal).
b. describe the process of facilitating communication (e.g., recognizing needs, seeking resources, matching needs and resources, encouraging efforts).
c. define the liaison function (e.g., "go between," linking interests, maintaining neutrality).

Skill: 4. The health educator must be able to create opportunities for voluntary participation in health education related activities.

Knowledge: The health educator must be able to:
a. explain the purposes of health education to those affecting and affected by such activities (e.g., define health education, show relationship between health and behavior, discuss needs for health education).
b. describe the utility of voluntary participation (e.g., value to affected individuals, greater cooperative efforts).
c. describe the process of developing opportunities for voluntary participation (e.g., needs assessment participation, participation in planning, designing feedback mechanisms).

The entry-level health educator, working with individuals, groups, and organizations, is responsible for:

Function: D. Disseminating information about health education programs. (26%)

Skill: 1. The health educator must be able to describe programs to health education professionals, decision-makers, consumers and the public by means of writing, speaking and other communication techniques.

Knowledge: The health educator must be able to:
a. describe health education programs through written and verbal techniques (e.g., writing a report, speaking about program characteristics, preparing overhead transparencies on program aspects).
b. identify designs for health education programs (e.g., didactic, research, demonstration, client-centered).
c. identify potential audiences for communications about health education programs (e.g., professional groups, consumers, decision-makers).
d. list indicators of program success for others (e.g., cost-benefits, changes in knowledge, attitudes and behaviors, program visibility).

Skill: 2. The health educator must be able to respond to inquiries from various sources about health education programs.

Knowledge: The health educator must be able to:
a. list steps necessary to develop a routine communication system (e.g., program descriptions, develop mailing list, inventory likely information outlets, respond to invitations).
b. distinguish among response techniques for applicability to a given request (e.g., form letters, brochures, journal articles, telephone calls).

Skill: 3. The health educator must be able to compile a record of audiences reached, inquiries about and reactions to health education programs.

Knowledge: The health educator must be able to:
a. describe the process of recording results from disseminating health education program information (e.g., time, dates, events, types of audience, responses).
b. identify information necessary for dissemination (e.g., program design, scope, intention, results to date).
c. state objectives of keeping records of program information dissemination (e.g., who is being reached, degree of support, indicators of effectiveness).

The entry-level health educator, working with individuals, groups and organizations, is responsible for:

Function: E. Advocating for health education in policy formulation.

Skill: 1. The health educator must be able to prepare written and oral testimony.

Knowledge:

The health educator must be able to:
a. describe essential components of written and oral testimony (e.g., concise, clear, brief, to the point).
b. identify the nature of the advocacy situation in planning testimony (e.g., likely consequences of decisions and indecision, reflection on other health education activities, maintaining opportunity for future action).
c. identify characteristics of policymaking bodies (e.g., legal, voluntary, opinion leaders).
d. identify arguments and data likely to persuade a given audience (e.g., changed behavior, concepts of health and health education, minimize disease processes).

Skill:

2. The health educator must be able to communicate with and respond to key officials and policymakers.

Knowledge:

The health educator must be able to:
a. identify key officials and policymakers at local, state, regional and national levels (e.g., school principals, state health officers, federal health and education officials).
b. describe communications for advocacy purposes (e.g., share information, ask for information, make specific requests, respond to specific requests).
c. list elements of a well-designed communication (e.g., timing, clarity, purposive, brevity).
d. recognize terminology and concepts important to key officials and decision-makers (e.g., political visibility, immediate effects, noncontroversial).

Skill:

3. The health educator must be able to interpret health/health education legislation and policies.

Knowledge:

The health educator must be able to:
a. describe legislative, regulative, and policy-formulative processes (e.g., public laws, federal regulations, school board policies).
b. relate laws, regulations and policies to health education programs (e.g., inclusions and exclusions, scope of influence, policy direction[s]).
c. explain legislation, regulations, or policies into clear terms to a given audience (e.g., clarifying implications, identifying professional issues, indicating necessary action).

Skill:

4. The health educator must be able to use persuasive strategies applicable to a given situation.

Knowledge:

The health educator must be able to:
a. describe persuasive strategies (e.g., emphasizing program successes, complimenting goals and objectives of well-regarded programs, predicting potential outcomes for proposed activities).
b. explain the value of health education to a given audience (e.g., enabling informed decision-making, enhancing quality of life, increasing autonomy among the public).
c. demonstrate application(s) of persuasive strategies to a given health education situation (e.g., developing a hospital-based health education program, continuing a sex education program in a public school, advocating for health education in legislative proposals).

Skill:

5. The health educator must be able to participate in health policy planning.

Knowledge:

The health educator must be able to:
a. define concepts of health policy planning (e.g., based on a set of principles or beliefs, direction for action, defines scope).
b. relate health education concepts to health policy planning (e.g., recognize educational aspects of health policy, articulate health education's role in policy proposals, illustrate contributions of health education to applications of health policy).

Skill: 6. The health educator must be able to analyze political processes related to health and health education.

Knowledge: The health educator must be able to:
a. describe political processes, especially as they apply to health education (e.g., recognizing varying interests, understanding positions of influence, knowledge of group dynamics).
b. match knowledge of political processes to a given audience and situation (e.g., consumers organizing around a problem, school board meetings, hospital professional staff activities).
c. explain how political information is gathered for constructive purposes (e.g., active listening, formal and informal meetings, sharing information, analyzing problems and situations).

Area of Responsibility II:

The entry-level health educator, working with individuals, groups and organizations, is responsible for:

DETERMINING THE APPROPRIATE FOCUS FOR HEALTH EDUCATION (10%)

The entry-level health educator, working with individuals, groups and organizations, is responsible for:

Function: A. Collecting information about populations of interest. (48%)

Skill: 1. The health educator must be able to gather data about health-related behaviors, needs and interests.

Knowledge: The health educator must be able to:
a. identify determinants related to specific health behaviors (e.g., genetic factors, fear, ignorance, perceptions, social influences).
b. list sources to determine health needs and interests (e.g., epidemiological data, public expressions, interview with school and health officials and those affected).
c. summarize data expressed in different forms (e.g., written reports, charts, graphs).

Skill: 2. The health educator must be able to identify social, cultural, environmental, organizational, and growth and development factors that affect health behavior, needs and interests.

Knowledge: The health educator must be able to:
a. describe social, cultural, and environmental factors which affect health behavior, needs and interests (e.g., belief systems, orientation in society, medical geography).
b. list methods to study social, cultural and environmental factors to determine impact on behavior of a given population (e.g., community survey, sociometric study, participant-observer, epidemiology).
c. identify growth and development patterns of various age groups (e.g., children, adolescents, older adults).
d. describe the social structure of the population to be served (e.g., ethnicity, socio-economic status, political makeup).

Skill: 3. The health educator must be able to identify available health-related resources.

Knowledge: The health educator must be able to:
a. describe health-related resources within a given area (e.g., hospitals, schools, public health departments, voluntary health associations).
b. match resources with a given population to resolve a health concern (e.g., define a community of solution, evaluate population in need and efficacy of resources).

The entry-level health educator, working with individuals, groups and organizations, is responsible for:

Function: B. Analyzing information to determine areas of need. (52%)

Activity: Selecting potential areas for health education.

Skill: 1. The health educator must be able to select potential area for health education.

Knowledge: The health educator is able to:
a. list elements essential for a successful health education program (e.g., fiscal and administrative support, personnel, program design).
b. recognize situational influences in priority selection (e.g., timing, other programs, interested parties, availability of resources).
c. describe the process of priority selection (e.g., determining criteria, recognizing environmental factors, analysis of available data, weighing alternatives).

Area of Responsibility III:

The entry-level health educator, working with individuals, groups, and organizations is responsible for:

PLANNING HEALTH EDUCATION PROGRAMS IN RESPONSE TO IDENTIFIED NEEDS (17%)

The entry-level health educator working with individuals, groups, and organizations is responsible for:

Function: A. Participating in the educational planning process (31%)

Skill: 1. The health educator must be able to acquire ideas and opinions from persons who may affect or be affected by the educational program.

Knowledge: The health educator must be able to:
a. identify resources for possible participants in planning (e.g., key people in the community, local, state and national directories, professional newletters, consumer-group publications).
b. define criteria to be used in selecting those to be involved in planning (e.g., interest, availability, demographic factors, political factors, diversity).
c. state ways of recruiting involvement of those who may be affected by the educational program (e.g., mass media, personal contact, town meetings, small group techniques, school board meetings).

Skill: 2. The health educator must be able to incorporate relevant ideas and opinions into the planning process.

Knowledge: The health educator must be able to:
a. describe methods of organizing ideas and opinions into a usable format (e.g., categories, time line, matrix, graphics).
b. identify criteria for selecting relevant information (e.g., feasibility, impact on health concern, applicability to health concern).

Skill: 3. The health educator must be able to develop an inventory of existing and potential political, organizational, economic and human resources for program implementation.

Knowledge: The health educator must be able to:
a. identify political and organizational resources to support planned programs (e.g., civic leaders, hospital administrators, meeting facilities, non-monetary assets, parents-students).
b. describe possible economic resources for health education (e.g., present budgetary allotments, private foundations, government agencies, corporations).
c. explain types of funding arrangements (e.g., grants, contracts, donations).
d. list various methods of staffing programs (e.g., paid staff, volunteers, sharing personnel with other groups or organizations).

Skill: 4. The health educator must be able to identify potential facilitators and barriers to the specific program.

Knowledge: The health educator must be able to:
a. identify administrative procedures which will inhibit or support the program (e.g., decision-making process, administrative system, views of administrative personnel).
b. describe potential barriers within the power structure of the community of interest (e.g., formal and informal leaders, economic and political power).
c. identify legal aspects affecting health education program (e.g., fluoridation, WIC program, amendments to P.L. 93-641, state school codes).
d. explain likely effects of the cost of program implementation (e.g., self-support, restrict other activities).
e. identify characteristics of social structures of the community (e.g., hospitals, schools, government, churches; health departments).

Skill: 5. The health educator must be able to secure administrative support for the program.

Knowledge: The health educator must be able to:
a. describe methods of communicating with administrators (e.g., written reports, oral presentations, discussions).
b. identify the value system of administrative personnel (e.g., beliefs, perceptions, cues to action).
c. list steps necessary to secure support (e.g., identify health concern, involve decision-makers in planning, keep communications open, make requests for support).
d. outline a budget for the proposed program (e.g., time, personnel, materials).
e. describe the expected outcomes of the program (e.g., increased compliance, acquired knowledge, adoption of new behaviors).

Skill: 6. The health educator must be able to establish a time frame for proposed program activities.

Knowledge: The health educator must be able to:
a. identify the processes of the program (e.g., organizing resources, securing cooperation, implementing the program, evaluating the results).
b. match program efforts with time needed to complete them (e.g., time needed to acquire personnel, time to conduct program activities, time needed to evaluate results).

The entry-level health educator, working with individuals, groups, and organizations, is responsible for:

Function: B. Participating in the selection of program objectives based upon information acquired as part of the planning process. (29%)

Skill: 1. The health educator must be able to identify specific behaviors affecting program concerns.

Knowledge: The health educator must be able to:
a. identify sources of information about health concerns (e.g., conference proceedings, professional journals, reports, Medline).
b. describe theoretical models of health education (e.g., health belief model, field theory, paradigms for needs assessment).
c. explain determinants of behavior (e.g., knowledge, values, influence of significant others, environmental cues).

Skill: 2. The health educator must be able to analyze the multiple and interrelated factors which affect health behaviors relevant to the program.

Knowledge: The health educator must be able to:
a. identify factors in the community which influence behaviors relevant to the program (e.g., cultural beliefs, housing for the elderly, transportation).
b. identify factors amenable to education (e.g., ignorance, misconceptions, fear).
c. describe interrelationships (e.g., concepts of interdependence, effects of disturbed relationships, principles of ecology).

Skill: 3. The health educator must be able to formulate measurable educational objectives.

Knowledge: The health educator must be able to:
a. describe criteria for setting educational priorities (e.g., health concerns amenable to education, urgency of the situation, desirability for program activity).
b. list different types of objectives (e.g., process, outcome, program, long term).
c. identify the necessary components of a well-written objective (e.g., who will do what, what shall be done, how achievement will be demonstrated).

The entry-level health educator, working with individuals, groups, and organizations, is responsible for:

Function: C. Designing educational programs consistent with specified educational objectives. (40%)

Skill: 1. The health educator must be able to formulate alternative educational methods.

Knowledge: The health educator must be able to:
a. match theory with specified educational objectives (e.g., field theory, diffusion of innovation, process of inquiry).
b. compare various educational methods (e.g., values clarification, community organization, group process).
c. identify resources for available methods (e.g., curricula designed, educational laboratories, professional journals).

Skill: 2. The entry-level health educator must be able to select educational methods applicable to the setting for implementation.

Knowledge: The health educator must be able to:
a. describe steps necessary to apply methods to a given educational situation (e.g., assess characteristics of the learners, determining legal requirements, assessing availability of resources).
b. recognize the need for flexibility in specifying educational methods during the planning process (e.g., aware of constant change, changes in resources available, differences among those for whom the program is intended.

Skill: 3. The health educator must be able to determine a sequence for educational experiences.

Knowledge: The health educator must be able to:
a. state concepts of designing scope and sequence of educational experiences (e.g., nature of the subject matter, readiness of the learners, relationships among subjects).
b. describe a sequence of learning opportunities for a given educational situation (e.g., introducing topics, reinforcing concepts, illustrating concept application to the other areas).

Skill: 4. The health educator must be able to provide mechanisms to assess selected educational methods.

Knowledge: The health educator must be able to:
a. describe methods for pretesting educational designs (e.g., pilot study, review by planning committee, review by individuals affected by the program).
b. match assessment mechanisms with a given educational situation (e.g., individual counseling in a hospital, elementary school, voluntary health agency).

Skill: 5. The health educator must be able to provide mechanisms to test program feasibility.

The health educator must be able to:
a. define concepts of feasibility for health education programs (e.g., applicability to the health concern, human and material resource availability, decision-maker support).
b. describe mechanisms for assessing feasibility (e.g., support statements by administrators, pilot tests, forecast of impact).
c. lists factors influencing program support and acceptance (e.g., involvement of relevant audience in planning process, maintaining communications, assessing availability of resources).

Area of Responsibility IV:

The entry-level health educator, working with individuals, groups, and organizations, is responsible for:

IMPLEMENTING PLANNED HEALTH EDUCATION PROGRAMS (19%)

The entry-level health educator, working with individuals, groups, and organizations, is responsible for:

Function: A. Assisting in mobilizing personnel needs to carry out the plan. (24%)

Skill: 1. The health educator must be able to present programs in selected settings to elicit participation, discussion, and necessary adaptations for favorable consideration.

Knowledge: The health educator must be able to:
a. list methods of presenting programs to others (e.g., written, oral, flip chart).
b. identify group process procedures useful to program presentation (e.g., small groups, autocratic vs. democratic procedures).
c. describe means to motivate audiences (e.g., benefits to audience, design of particular audience, appeal to desirable qualities).
d. describe conditions for favorable adoption of programs (e.g., program addresses, important concerns, degree of feasibility, investment required).

Skill: 2. The health educator must be able to obtain specific commitments from decision-makers and all personnel who will be involved in the program.

Knowledge: The health educator must be able to:
a. list steps needed to obtain commitments (e.g., present program, clarify and answer questions, request cooperation).
b. describe forms of commitment needed from those involved (e.g., program approval, time, level of and place for participation, resources needed).
c. match program components with those capable of contributing to them (e.g., administrator with program approval, audiovisual specialist with instructional media).

Skill: 3. The health educator must be able to train personnel to carry out the program as needed.

Knowledge: The health educator must be able to:
a. describe the process for assessing training needs (e.g., listing skills needed, reviewing skills of available personnel, comparing skills with program requirements).
b. describe steps for implementing training programs (e.g., specify learning objectives, selecting instructional methods, carrying out methods, evaluating).

The entry-level health educator, working with individuals, groups, and organizations, is responsible for:

Function: B. Securing operational resources necessary to carry out the plan. (30%)

Skill: 1. The health educator must be able to allocate resources budgeted for the program.

Knowledge: The health educator must be able to:
a. identify a variety of budgeting systems (e.g., zero-based budgeting, management by objectives, PPBS).
b. list steps necessary for budget preparation (e.g., specifying objectives and methods, judging what is needed to carry out the program, specifying time, materials and personnel required).
c. describe methods of budget presentation (e.g., personal and written presentations, flow charts, rationale for requests).

Skill: 2. The health educator must be able to arrange for physical facilities for the program.

Knowledge: The health educator must be able to:
a. list steps necessary to arrange for facilities (e.g., contact involved personnel, obtain agreement, schedule time).
b. identify facilities useful to the health education program (e.g., classroom, hotel meeting rooms, conference rooms, physical environments conducive to education).

Skill: 3. The health educator must be able to acquire needed educational materials.

Knowledge: The health educator must be able to:
a. describe available educational materials (e.g., curricula guides, audiovisuals, games).
b. identify sources of educational materials (e.g., identifying needed materials, requisitioning materials, checking budget expenditures).

Skill: 4. The health educator must be able to prepare educational materials as needed.

Knowledge: The health educator must be able to:
a. identify the lack of materials needed for the program (e.g., available materials, inadequate or inappropriate, gaps in available materials, rapid changes in program content).
b. describe the process of developing materials (e.g., identify need, select likely format, develop materials, test applicability).

c. explain the advantages and disadvantages of self-developed materials (e.g., advantage of design for particular audience, disadvantage in cost, advantage in program effectiveness).
d. identify other sources to assist in development of materials (e.g., other school or hospital personnel, personnel in other agencies or departments).

The entry-level health educator, working with individuals, groups, and organizations, is responsible for:

Function: C. Carrying out the educational program for sharing information, influencing behavior, and resolving problems. (47%)

Skill: 1. The health educator must be able to use individualized approaches to educational programs.

Knowledge: The health educator must be able to:
a. describe applications of individualized approaches (e.g., crisis-intervention, scheduled appointments, teachable moments).
b. identify principles of counseling (e.g., active listening, directive and non-directive probing, summarizing).
c. discuss the preparation needed for individualized learning (e.g., sensitivity of subject matter, knowledge of individual, knowledge of resources for individualized experiences).
d. identify available technology for individualized learning (e.g., programmed texts, self-assessment and achievement instruments, computer programs).

Skill: 2. The health educator must be able to apply lecture techniques to program activities.

Knowledge: The health educator must be able to:
a. describe principles of public speaking (e.g., speaking with clarity, keeping the message in focus, maintaining poise).
b. describe the process of making oral presentations to various groups in various settings (e.g., identify needed information for patients, drawing attention to subject in professional meetings, summarizing major points presented in a classroom).
c. identify visual aids for making oral presentations (e.g., graphs, transparencies, flip charts).
d. describe uses of oral presentations (e.g., focus on subject, introducing information, uniform messages to an audience).

Skill: 3. The health educator must be able to employ group process techniques in program activities.

Knowledge: The health educator must be able to:
a. describe processes of a variety of groups (e.g., focusing on a subject of interest in a workshop, generating alternative views in a discussion group, accomplishing tasks in ad hoc committees).
b. list principles of problem-solving (e.g., identifying the problem, working on the problem, proposing alternative solutions).
c. describe various decision-making processes (e.g., coercive, democratic, consensus).
d. identify the functional roles of group participants (e.g., leader, facilitator, blocker).

Skill: 4. The health educator must be able to apply community organization techniques in program activities.

Knowledge: The health educator must be able to:
a. state the principles of community organization (e.g., defining concerns of the community, identifying leaders, organizing community elements).
b. describe likely applications of community organization (e.g., complex behavioral concerns affecting groups, problems amenable to concerted efforts by previously fragmented resources, need to establish relationships among community groups).

c. explain the advantages and disadvantages of self-developed materials (e.g., advantage of design for particular audience, disadvantage in cost, advantage in program effectiveness).
d. identify other sources to assist in development of materials (e.g., other school or hospital personnel, personnel in other agencies or departments).

The entry-level health educator, working with individuals, groups, and organizations, is responsible for:

Function: C. Carrying out the educational program for sharing information, influencing behavior, and resolving problems. (47%)

Skill: 1. The health educator must be able to use individualized approaches to educational programs.

Knowledge: The health educator must be able to:
a. describe applications of individualized approaches (e.g., crisis-intervention, scheduled appointments, teachable moments).
b. identify principles of counseling (e.g., active listening, directive and non-directive probing, summarizing).
c. discuss the preparation needed for individualized learning (e.g., sensitivity of subject matter, knowledge of individual, knowledge of resources for individualized experiences).
d. identify available technology for individualized learning (e.g., programmed texts, self-assessment and achievement instruments, computer programs).

Skill: 2. The health educator must be able to apply lecture techniques to program activities.

Knowledge: The health educator must be able to:
a. describe principles of public speaking (e.g., speaking with clarity, keeping the message in focus, maintaining poise).
b. describe the process of making oral presentations to various groups in various settings (e.g., identify needed information for patients, drawing attention to subject in professional meetings, summarizing major points presented in a classroom).
c. identify visual aids for making oral presentations (e.g., graphs, transparencies, flip charts).
d. describe uses of oral presentations (e.g., focus on subject, introducing information, uniform messages to an audience).

Skill: 3. The health educator must be able to employ group process techniques in program activities.

Knowledge: The health educator must be able to:
a. describe processes of a variety of groups (e.g., focusing on a subject of interest in a workshop, generating alternative views in a discussion group, accomplishing tasks in ad hoc committees).
b. list principles of problem-solving (e.g., identifying the problem, working on the problem, proposing alternative solutions).
c. describe various decision-making processes (e.g., coercive, democratic, consensus).
d. identify the functional roles of group participants (e.g., leader, facilitator, blocker).

Skill: 4. The health educator must be able to apply community organization techniques in program activities.

Knowledge: The health educator must be able to:
a. state the principles of community organization (e.g., defining concerns of the community, identifying leaders, organizing community elements).
b. describe likely applications of community organization (e.g., complex behavioral concerns affecting groups, problems amenable to concerted efforts by previously fragmented resources, need to establish relationships among community groups).

c. distinguish between approaches to community organizations (e.g., social action compared to locality development compared to social planning and organizational development).

Skill: 5. The health educator must be able to use instructional media.

Knowledge: The health educator must be able to:
a. describe the use of audiovisual equipment in program activities (e.g., films to stimulate discussion, videotape to record skill demonstration, overhead projector to display graphic material).
b. identify educational television resources (e.g., local public service programs, commercially produced series, national campaign materials).
c. describe use of simulations and games (e.g., role playing for value clarification, games for understanding group processes, case studies for anlaysis of behavior).
d. explain applications of programmed learning (e.g., computer programs to illustrate application of knowledge, teaching machines to reinforce knowledge, programmed texts to introduce new material).

Skill: 6. The health educator must be able to employ mass media in health education activities.

Knowledge: The health educator must be able to:
a. explain how press releases are written (e.g., use of facts, identifying who and what was involved, where actions occurred).
b. describe how public information announcements are prepared (e.g., developing message, identifying concern, transmission of facts).
c. describe how articles on health topics are written for popular magazines and journals (e.g., understanding editorial perspective, writing for mass appeal, selecting topics of wide interest).
d. identifies the role for health educators consulting on media content (e.g., looking for health content, identifying opportunities, providing needed information).
e. describes the use of media in relationship to educational objectives (e.g., newspapers and cost-benefit, television and age groups reached, direct mail and reaching specified audience).

Skill: 7. The health educator must be able to coordinate necessary resources.

Knowledge: The health educator must be able to:
a. describe the process of coordination (e.g., facilitation, communication, feedback).
b. identify a variety of administrative approaches (e.g., coercive, democratic, committee decision-making).
c. explain the role each resource plays in carrying out the program (e.g., physical facilities, community volunteers, audiovisual materials).

Skill: 8. The health educator must be able to monitor the program to assure that it is being implemented as designed or modified.

Knowledge: The health educator must be able to:
a. describe principles of supervision (e.g., communicating, directing, following up).
b. identify the process of developing feedback systems in program operations (e.g., written and oral reports, data summaries, problem reporting).
c. match program operations with progress toward achieving objectives (e.g., audiences reached, behaviors demonstrated, concerns resolved).
d. report barriers to and facilitators for achieving specified objectives (e.g., time, materials, culture).

Skill: 9. The health educator must be able to disseminate planned programs to others.

Knowledge: The health educator must be able to:
a. identify methods of dissemination (e.g., demonstrations, presentations, publications).
b. describe the necessity for disseminating program information (e.g., adoption by others, minimize duplications, upgrade the quality of programs).

Area of Responsibility V:

The entry-level health educator, working with individuals, groups and organizations, is responsible for:

EVALUATING HEALTH EDUCATION (12%)

The entry-level health educator, working with individuals, groups and organizations, is responsible for:

Function: A. Participating in developing a design to assess achievement of educational objectives. (24%)

Skill: 1. The health educator must be able to assist in specifying indicators of program success.

Knowledge: The health educator must be able to:
a. differentiate between what can and cannot be measured (e.g., knowledge gained, changes in morbidity rates due to health education).
b. translate objectives into specific indicators (e.g., knowledge gained, values stated, behaviors mastered).
c. describe range of methods and techniques used for educational measurement (e.g., inventories, scales, competency tests).
d. list steps involved in evaluative activities (e.g., setting standards, specifying objectives, developing criteria for achievement of objectives).

Skill: 2. The health educator must be able to help to establish the scope for program evaluation.

Knowledge: The health educator must be able to:
a. define scope of evaluation efforts (e.g., match standards with goals, explain relationship between activities and outcomes).
b. describe feasibility of evaluative activities (e.g., time availability, resources, setting, nature of the program).
c. explain the beliefs and purposes behind health education activities (e.g., value to consumers, increase control over health matters, informed public).

Skill: 3. The health educator must be able to help develop methods for evaluating programs.

Knowledge: The health educator must be able to:
a. identify various measures for determining knowledge, attitudes and behavior (e.g., questionnaires, self-assessment inventories, knowledge tests).
b. describe data available for evaluation (e.g., program attendance, reports of behaviors, survey data, letters from consumers and others, test scores).
c. list strengths and weaknesses of various data, collection methods (e.g., value of self-report, expense of observing behavior).

Skill: 4. The health educator must be able to participate in the specification of instruments for data collection.

Knowledge: The health educator must be able to:

a. describe advantages and disadvantages of "homemade" and commercial instruments (e.g., utility, cost, timeliness).
b. identify sources of instruments (e.g., professional organizations, research organizations, consultants, textbook publishers).

Skill: 5. The health educator must be able to assist in the determination of samples needed for evaluation.

Knowledge: The health educator must be able to:
a. define sample concepts (e.g., stratified, random, convenience, universe).
b. identify strengths and weaknesses of sampling techniques (e.g., sampling error, skewed results, normal distributions, precision of estimates).

Skill: 6. The health educator must be able to assist in the selection of data useful for accountability analysis.

Knowledge: The health educator must be able to:
a. describe the uses of cost-benefit analysis (e.g., amount of investment needed for program success, efficacy of health education).
b. describe uses of cost effectiveness analysis (e.g., modify programs, select alternative(s) from competing choices).

The entry-level health educator, working with individuals, groups and organizations, is responsible for:

Function: B. Assembling resources required to carry out evaluation. (22%)

Skill: 1. The health educator must be able to acquire facilities, materials, personnel and equipment.

Knowledge: The health educator must be able to:
a. describe facilities, materials and equipment needed (e.g., telephones, typewriters, computers).
b. identify required expertise and sources for expertise (e.g., survey methodology from universities, physician for clinical study, experts in evaluation).
c. identify ways of obtaining necessary facilities, materials, expertise and equipment (e.g., personal visitations, formal requests, budgetary requisitions).

Skill: 2. The health educator must be able to train personnel for evaluation as needed.

Knowledge: The health educator must be able to:
a. describe the process for assessing training needs (e.g., listing skills needed, reviewing skills of available personnel, comparing skills with program requirements).
b. describe steps for implementing training programs (e.g., specify learning objectives, selecting instructional methods, carrying out methods, evaluating).

Skill: 3. The health educator must be able to secure the cooperation of those affecting and affected by the program.

Knowledge: The health educator must be able to:
a. describe how to involve relevant parties in the evaluation process (e.g., explaining importance, answering questions, asking for cooperation).
b. identify importance of safeguarding rights of individuals involved (e.g., explanation of purposes and procedures, confidential record-keeping).
c. explains methods to maintain interest in program evaluation (e.g., importance of the work, reinforcement of effort, communication techniques, presentation of evaluation results).

The entry-level health educator, working with individuals, groups and organizations, is responsible for:

Function: C. Helping to implement the evaluation design. (30%)

Skill: 1. The entry-level health educator must be able to collect data through appropriate techniques.

Knowledge: The health educator must be able to:
a. identify the applicability of various techniques to a given situation (e.g., observations, interviews, questionnaires, written tests).
b. describe how to acquire data from existing sources (e.g., scan newspapers, review journal articles, scan morbidity and mortality data, health records).
c. distinguish between quantitative and qualitative data (e.g., counts vs. expressions of satisfaction, changes in physical indices vs. loss of interest).

Skill: 2. The health educator must be able to analyze collected data.

Knowledge: The health educator must be able to:
a. identify basic statistical measures (e.g., counts, means, median).
b. describe processes of statistical analysis (e.g., selected analysis based on stated concern, collecting data, use of statistical techniques).
c. explain the results of statistical analysis (e.g., report data, make inferences, draw conclusions).
d. identify steps in analyzing qualitative data (e.g., developing categories, ascribing means to data, making inferences).
e. explain how data may be kept and used as needed (e.g., record keeping system, computer storage, filing systems, progress reports).

Skill: 3. The health educator must be able to interpret results of program evaluation.

Knowledge: The health educator must be able to:
a. identify relationships between analyzed data and program objectives (e.g., objectives met, reasons for lack of achievement, changes in program reflected in data).
b. recognize importance of looking for unanticipated results (e.g., appearance of seemingly unrelated results, significant deviations from what was expected).
c. identify variable necessary for interpretation of data (e.g., SES, sex, age, medical diagnosis).
d. recognize risks of drawing conclusions not fully justified by the data (e.g., program's value to other fields, program successes, program failures).

The entry-level health educator, working with individuals, groups and organizations, is responsible for:

Function: D. Communicating results of evaluation. (23%)

Skill: 1. The health educator must be able to report the processes and results of evaluation to those interested.

Knowledge: The health educator must be able to:
a. describe how to organize, write and report findings (e.g., objectives, activities, results, interpretation, conclusions).
b. translate evaluation findings into terms understandable by others (e.g., professionals, consumers, administrators).
c. explain various ways to depict findings (e.g., graphs, slides, flip charts).

Skill: 2. The health educator must be able to recommend strategies for implementing results.

Knowledge: The health educator must be able to:
a. list strategies that can be used for implementation (e.g., involve those affected, explain results to given audiences, propose new or modified programs).
b. identify implications from findings for future programs or other actions (e.g., alert others beyond programs, publish reports on programs and their evaluation).

Skill: 3. The health educator must be able to incorporate results into planning and implementation processes.

Knowledge: The health educator must be able to:
a. describe how program operations can be modified based on evaluation results (e.g., discussions with personnel, proposed changes in objectives/methods/content).
b. explain how evaluation results are part of the planning process (e.g., formative vs. summative evaluation, self-renewal of programs.

Area of Responsibility VI:

The entry-level health educator, working with individuals, groups and organizations, is responsible for:

COORDINATING SELECTED HEALTH EDUCATION ACTIVITIES (11%)

The entry-level health educator, working with individuals, groups and organizations, is responsible for:

Function: A. Assisting personnel to carry out health education activities. (38%)

Skill: 1. The health educator must be able to contribute to cooperation and feedback among personnel related to the program.

Knowledge: The health educator must be able to:
a. identify structures, goals and objectives of organizations and their programs (e.g., organization charts, committees, annual reports, interviews with administrators).
b. identify existing formal and informal channels of communication (e.g., meeting minutes, memoranda, social activities, coffee breaks).
c. describe methods for establishing cooperation (e.g., defining common interests, seeking interested parties, looking for complementary expertise).
d. explain methods of improving communication (e.g., ad hoc groups, personal contact, bulletins, newsletters).
e. identify formal and informal leadership (e.g., appointed leaders, opinion leaders).

Skill: 2. The health educator must be able to reconcile differences in approach, timing and effort among individuals.

Knowledge: The health educator must be able to:
a. list methods of conflict reduction (e.g., mediation, arbitration, interpretation, negotiation).
b. identify roles individuals assume in organizations (e.g., facilitator, innovator, blocker).
c. explain common interests and differences of members of an organization with respect to a given concern (e.g., who should be educating patients, role of school nurse in education, effectiveness of W.I.C. program, what should be taught in school).
d. recognize differences in perceptions among individuals (e.g., age, sex, race, education, income, occupation).

Skill: 3. The health educator must be able to act as liaison between individuals within and outside of groups and organizations.

Knowledge: The health educator must be able to:
a. identify purposes and goals of own organization in relation to others (e.g., states goals and purposes of various groups, compares and contrasts differences in organizations' goals and purposes).
b. describe the scope of liaison function (e.g., limitations, authority, responsibility).
c. explains the processes involved in acting as a liaison (e.g., initial contact, reporting back, following up).

Skill: 4. The health educator must be able to facilitate group meetings involving those concerned with the subject.

Knowledge: The health educator must be able to:
a. describe the process of convening meetings (e.g., agenda, location, participants, parliamentary procedures).
b. explain the role of the facilitator (e.g., convene meeting, selecting group leader(s), assisting completion of tasks).
c. identify roles individuals assume in meetings (e.g., innovator, blocker, socializer).
d. name various techniques of group process (e.g., role playing simulation, fish bowl, nominal group).
e. differentiate between task and process activities of a group (e.g., time to complete task, involvement of members in discussion).

The entry-level health educator, working with individuals, groups and organizations, is responsible for:

Function: B. Promoting awareness of health education's contributions to achieving goals. (40%)

Skill: 1. The health educator must be able to assure that health education is considered when priorities are determined.

Knowledge: The health educator must be able to:
a. list those involved in determining priorities (e.g., administrators, opinion leaders, consumers, parents).
b. describe procedures for calling health education to the attention of decision-makers (e.g., present data evidence, prepare proposals, prepare position papers).
c. identify methods of participation in selecting goals and objectives affecting health education programs (e.g., giving information, pointing out educational components of health education programs).

Skill: 2. The health educator must be able to participate in developing health education proposals to meet goals.

Knowledge: The health educator must be able to:
a. list steps in developing health education program proposals (e.g., gathers data, defines educational audience, specifies needed resources).
b. identify relationships between organizational goals and health education purposes (e.g., compare purposes with educational needs, formulate tentative designs).

Skill: 3. The health educator must be able to promote integration of health education programs with other facets of organizational activities.

Knowledge: The health educator must be able to:
a. describe methods of introducing health education activities into organizational programs (e.g., health education in maternal and child health programs, health education aspects of social studies).
b. identify points of entry for health education into other programs (e.g., nurses teaching patients, health concepts in psychology classes).

The entry-level health educator, working with individuals, groups and organizations, is responsible for:

Function: C. Carrying out designated administrative activities. (21%)

Skill: 1. The health educator must be able to supervise resource personnel.

Knowledge: The health educator must be able to:
a. describe functions of supervisors (e.g., directs personnel toward objectives, orients personnel to program purposes).
b. list methods of communicating with staff (e.g., memoranda, group meetings, individual consultation).
c. describe role of resource personnel in the organization (e.g., accomplishing program and organization objectives, relationship of personnel activities with the group's or organization's purposes).

Skill: 2. The health educator must be able to respond to requests from administrative personnel for information or assistance.

Knowledge: The health educator must be able to:
a. identify sources of requested information (e.g., journals, reports, program records, memoranda).
b. describe the processes of responding to requests for assistance (e.g., knows when requests are inappropriate, clarifies the nature of the request, secures information needed, performs tasks).

Skill: 3. The health educator must be able to organize resources to complete specified tasks.

Knowledge: The health educator must be able to:
a. identify resources within and outside the group or organization (e.g., personnel, equipment, budget, time).
b. list steps needed in order to complete tasks (e.g., when, where, how).
c. identify others who will be able to assist in completion of specified tasks (e.g., administrators, staff, other program personnel).

Skill: 4. The health educator must be able to monitor budget expenditures.

Knowledge: The health educator must be able to:
a. translate program activities into budget expenditure categories (e.g., personnel expenses for time, equipment purchases, resource material expenditures).
b. list steps in developing a budget for an activity (e.g., identify objectives, identify resources necessary to meet activity objectives).
c. describe the process of developing a systematic review of budget expenditures for reporting purposes (e.g., compare budget allowances with amounts expended, identify budgetary problems, present status reports).

Skill: 5. The health educator must be able to articulate progress of and requirements for health education activities to administrative personnel.

Knowledge: The health educator must be able to:
a. list steps necessary to develop feedback mechanisms (e.g., written and oral reports, charts, graphs, pamphlets).
b. describe communication patterns in administrative structures (e.g., formal, informal, line and staff).
c. explain steps necessary to evaluate the progress of health education activities (e.g., compare activities to objectives, document activities, select criteria for evaluating success).

Skill: 6. The health educator must be able to change administration of health education activities in accordance with organizational needs.

Knowledge: The health educator must be able to:
a. describe authority - responsibility relationships within organization (e.g., line-staff, autocratic, democratic, committee).
b. explain steps necessary to change program directions (e.g., redefining objectives, re-allocating resources, explaining changes to those involved).
c. identify organizational components involved in changing programs (e.g., personnel, facilities, budget).
d. describe influences beyond the organization which change activities (e.g., consumer groups, PTA, public expressions).

Area of Responsibility VII:

The entry-level health educator, working with individuals, groups, and organizations, is responsible for:

ACTING AS A RESOURCE FOR HEALTH AND HEALTH EDUCATION (11%)

The entry-level health educator, working with individuals, groups, and organizations, is responsible for:

Function: A. Gathering information from various sources regarding needs, concerns and interests. (18%)

Skill: 1. The health educator must be able to search media sources for health information.

Knowledge: The health educator must be able to:
a. identify media sources of health information (e.g., newspapers, films, television).
b. analyze the validity of health information (e.g., "fad" diets, laetrile therapy, VD from toilet seats).
c. recognize information of value to the health of community groups (e.g., immunization levels of school children, swine flu vaccine, PCB contamination).

Skill: 2. The health educator must be able to conduct literature searches.

Knowledge: The health educator must be able to:
a. describe sources of valid health information (e.g., journals, texts, information retrieval systems, reports, organizations).
b. list steps necessary for searching literature (e.g., identifying the need for the search, matching needs with likely sources, pursuing leads, judging the quantity and quality of the literature).
c. organize information in a useful form (e.g., categorizing, cross-referencing, cataloging).

Skill: 3. The health educator must be able to use survey techniques to acquire data.

Knowledge: The health educator must be able to:
a. identify survey techniques (e.g., mailed vs. telephone surveys, household interviews, open ended vs. close ended questions).
b. list steps in the survey process (e.g., sample selection, instrument construction, demographic data requirements, avoiding bias).
c. describe the administration of surveys (e.g., asking questions, recording responses, training interviewers).

Skill: 4. The health educator must be able to attend seminars, symposia, conferences and various meetings.

Knowledge: The health educator must be able to:
a. identify groups and organizations at national, state and local levels which conduct various kinds of meetings (e.g., APHA, California School Health Association, local HSA).
b. recognize relevant topics within meeting programs (e.g., comprehensive school health curricula, cost-benefits in community-based health education, role of health educators in clinical settings).
c. outline important points salient to meeting agendas (e.g., pro-choice vs. right to life on abortion, health education reimbursement in hospital daily charge vs. fee-for-service, voucher system for school health educators).

Skill: 5. The health educator must be able to gather information on an informal basis.

Knowledge: The health educator must be able to:
a. identify individuals who are capable of specifying health information (e.g., medical personnel, school officials, interested lay people, opinion leaders).

b. describe how information can be gathered (e.g., during formal meetings, participation in civic events, social occasions).

Skill: 6. The health educator must be able to organize resource materials for accessibility.

Knowledge: The health educator must be able to:
a. list steps necessary to organize files (e.g., reviewing available systems, establishing categories, specifying the scope of the system).
b. identify health agencies and their health education programs, educational materials and services (e.g., identify health associations, hospitals, public health departments, schools, curricular guides, audiovisual materials, current efforts).
c. list community resources which have information about health and health education needs and interests. (e.g., colleges and universities, HSA's, hospitals, public health departments, labor unions).
d. describe plans to update files (e.g., scan popular and professional literature, meet with personnel of various agencies, meetings).

The entry-level health educator, working with individuals, groups, and organizations, is responsible for:

Function: B. Responding to requests for information. (21%)

Skill: 1. The health educator must be able to match information with requests.

Knowledge: The health educator must be able to:
a. outline the health and health education information and resources gathered (e.g., health concerns, educational programs, educational materials).
b. recognize the context of requests (e.g., consumer requests on nutrition, physician requests for educational program materials, teacher requests for drug information).
c. select information which meets the request (e.g., giving facts plus resources, describing limitations of knowledge or resources, judging the adequacy of information).

Skill: 2. The health educator must be able to refer requestors to applicable sources.

Knowledge: The health educator must be able to:
a. recognize limitations on information available (e.g., local conditions, library access, communications with other health professionals).
b. describe resources which can respond to the request (e.g., school nurse, physician, social worker).
c. match requestors with those capable of responding to the request (e.g., nutritionist on food selection, physician on disease processes, health officer on immunization programs).
d. describe the referral process (e.g., acknowledging the request, suggesting alternative resources, following up).

Skill: 3. The health educator must be able to respond to information requests.

Knowledge: The health educator must be able to:
a. describe how requests may be answered verbally (e.g., telephone discussion, personal appointment, site visitation).
b. explain how requests may be answered in writing (e.g., sending pamphlets or clippings, writing letters, preparing a report).
c. describe processes for systematically responding to requests (e.g., recording requests, acknowledging requests, developing a reminder system).

The entry-level health educator, working with individuals, groups, and organizations, is responsible for:

Function: C. Initiating opportunities for consultation. (12%)

Skill: 1. The health educator must be able to interpret one's health education skills for others.

Knowledge: The health educator must be able to:
a. list own areas of emphasis in preparation and experience (e.g., a particular setting, theoretical view, group process skills).
b. illustrate application of expertise to varying situations for others (e.g., group process skills applied to a school setting, industrial setting, medical care setting).

Skill: 2. The health educator must be able to assess sites for consultation activities.

Knowledge: The health educator must be able to:
a. identify settings for health education (e.g., school, public health department, hospital).
b. identify specific needs within a setting (e.g., lack of knowledge, behavioral concerns, concern over values).
c. list process of assessing sites for consultation (e.g., discovering needs, matching skills with needs).

Skill: 3. The health educator must be able to seek opportunities to provide consultative services.

Knowledge: The health educator must be able to:
a. list skills necessary to address identified needs (e.g., mass media programs, program planning, evaluation).
b. explain different methods of approaching consulting opportunities (e.g., responding to requests, formal proposals, informal discussions).
c. describe the process of providing services (e.g., inventory needs and expertise, initiating discussions, discussion of possible service plans).

Skill: 4. The health educator must be able to formulate an agreement to provide consultative services.

Knowledge: The health educator must be able to:
a. describe the provisions needed to be included in a consultative agreement (e.g., scope of work, compensation, time period, relationship with the organization).
b. describe various methods of formulating an agreement (e.g., written and oral contracts, informal arrangements).

The entry-level health educator, working with individuals, groups, and organizations, is responsible for:

Function: D. Seeking consultation from others. (13%)

Skill: 1. The health educator must be able to define consultative needs.

Knowledge: The health educator must be able to:
a. identify needs for which there are inadequate resources within an organization (e.g., lack of group process skills needed for system analysis, dissatisfaction with evaluation efforts).
b. state priorities among identified needs for consultation (e.g., compares needs, assigns values, ranks needs).
c. list criteria for selecting priorities (e.g., importance, difficulty, timeliness).

Skill: 2. The health educator must be able to select consultant(s) to assist personnel.

Knowledge: The health educator must be able to:
a. define expertise required (e.g., matches need with health education skills, compare consultative resources with program needs).
b. describe the processes necessary for developing a consultative relationship (e.g., initiating discussions with consultants, review resumes, interview candidates).

c. explain the procedures for formulating a consultative agreement (e.g., what the organization will do, what the consultant will do, time period, compensation).

The entry-level health educator, working with individuals, groups, and organizations, is responsible for:

Function: E. Providing consultation to others. (10%)

Skill: 1. The health educator must be able to identify the nature of the consultation requested.

Knowledge: The health educator must be able to:
a. name area(s) of interest for consultation requesting organization (e.g., program revision, system analysis planning).
b. distinguish needs for which the health educator has skills from expressed needs (e.g., behavioral concerns, misconceptions, planning).
c. define the consultative need (e.g., skills, resources, process).
d. match requests for consultation with objectives of the organization (e.g., evaluating programs with patient care objectives, planning programs consistent with an industry's objectives).

Skill: 2. The health educator must be able to establish consultative relationships.

Knowledge: The health educator must be able to:
a. describe the process of developing consultative relationships (e.g., finding need, finding resources, negotiating services).
b. describe the process of formulating an agreement for consultation (e.g., formal vs. informal, specifications, compensation).

Skill: 3. The health educator must be able to assist in problem analysis.

Knowledge: The health educator must be able to:
a. identify steps in the problem solving process (e.g., identifying problems, defining problems, proposing solutions).
b. describe the process of analyzing needs (e.g., comparison of objectives with program performance, expressions of concern, identifiable gaps).
c. state criteria necessary for problem analysis (e.g., importance of the problem, prevalence, political significance).
d. identify indicators of problems (e.g., number of broken appointments, self-reports by consumers, changes in morbidity).

Skill: 4. The health educator must be able to develop alternative solution to problems.

Knowledge: The health educator must be able to:
a. describe objectives of the consultative relationship (e.g., changes in selected behavior modifying existing programs, training personnel).
b. identify steps in formulating alternative solutions (e.g., identifying resources, stating courses of action, matching alternatives with objectives).

Skill: 5. The health educator must be able to participate in the selection of solutions.

Knowledge: The health educator must be able to:
a. define relationship with consultee (e.g., make recommendations, report findings, train personnel).
b. match alternative solutions with objectives, available resources, and perspectives of the consultee (e.g., audiovisual program with parent participation, equipment and facilities availability).

c. select alternatives most likely to efficiently achieve objectives (e.g., training community health aides for screening programs).

Skill: 6. The health educator must be able to evaluate consultative experiences.

Knowledge: The health educator must be able to:
a. define criteria for evaluation (e.g., reduced morbidity, personnel skills demonstrated, increased levels of participation).
b. describe method(s) of evaluating consultative efforts (e.g., documenting the process, listing quantifiable changes).
c. explain the process of interpreting collected evaluative data (e.g., comparison of data with objectives, reviewing process, drawing conclusions).

The entry-level health educator, working with individuals, groups and organizations, is responsible for:

Function: F. Preparing others to perform health education-related skills. (11%)

Skill: 1. The health educator must be able to assess needs for skill development.

Knowledge: The health educator must be able to:
a. identify needs for preparation in selected skills (e.g., expressed interests, lack of skills).
b. describe procedures for evaluating needs for skill development (e.g., observation of work practices, formal skill tests, review of program operations).

Skill: 2. The health educator must be able to specify learning objectives.

Knowledge: The health educator must be able to:
a. state what is needed to be learned (e.g., group process skills, evaluation techniques, decision-making processes).
b. describe evidence of performance in measurable terms (e.g., using Bloom's Taxonomy, Mager-type objectives).

Skill: 3. The health educator must be able to select appropriate instructional methods.

Knowledge: The health educator must be able to;
a. list alternative methods available (e.g., didactic, simulation, discussion, demonstration)
b. match methods with specified objectives (e.g., group process skills demonstrated in performing a task, introduction of skill concepts through a lecture, analysis skills performed using simulations).
c. identify human and material resources needed to implement methods (e.g., time, facilities, personnel, equipment).

Skill: 4. The health educator must be able to carry out effective instruction.

Knowledge: The health educator must be able to:
a. describe the process of applying educational methods (e.g., convening a group, presenting skills, learner demonstration of skills, reinforcement of learning).
b. list indicators of achievement (e.g., degree of proficiency, values stated, knowledge expressed).
c. outline steps necessary to monitor instructional activities (e.g., comparing activities with objectives, making corrections where indicated, keeping communications open).
d. explain the process of coordinating resources (e.g., scheduling activities, sequencing learning opportunities, involving those interested and affected).

Skill: 5. The health educator must be able to evaluate results of the skill development process.

Knowledge: The health educator must be able to:
a. define criteria for evaluating the program (e.g., improvements in skill, acceptable adoption of skills, acceptance by decision-makers).
b. list methods for evaluating programs (e.g., number of participants, activities completed, skills demonstrated, evidence of adoption).
c. describe the process of interpreting results (e.g., collecting data, applying analytical devices comparing results with objectives, drawing conclusions).

The entry-level health educator, working with individuals, groups and organizations, is responsible for:

Function: G. Providing educational resource materials. (14%)

Skill: 1. The health educator must be able to identify educational resource materials which meet the needs of individuals, groups or organizations.

Knowledge: The health educator must be able to:
a. describe sources of health education materials (e.g., library access systems, professional organizations, publishers).
b. list resource material needs for the population of interest (e.g., quantity, quality, specific educational concern).
c. match material with needs (e.g., pamphlets with hypertension program, nutritional information for school children, curricula materials for nursing personnel).

Skill: 2. The health educator must be able to evaluate the applicability of resource materials.

Knowledge: The health educator must be able to:
a. describe criteria for acceptability of resource materials (e.g., clarity of language, acceptable format, cost of materials).
b. explain the process of evaluating resource materials to fulfill a specific need (e.g., matching needs with resources, choosing among alternatives, testing the applicability of materials).

Skill: 3. The health educator must be able to acquire selected resource materials.

Knowledge: The health educator must be able to:
a. identify fiscal resources within the program budget (e.g., line item, organizational purchasing, special requisition).
b. describe how materials will be organized for accessibility (e.g., displays, inventory system, communications with those in need).
c. explain procurement procedures within the organization (e.g., requisitions, verbal requests, contracts).

Skill: 4. The health educator must be able to distribute educational materials.

Knowledge: The health educator must be able to:
a. describe various procedures for distributing materials (e.g., displays in waiting rooms, direct mail to consumers, handouts to students).
b. identify intra- and extra-organizational resources for material distribution (e.g., consumer groups, P.T.A., hospital, public relations department).

CURRICULUM VITAE

Pamela E. MacAskill
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Education:

Bachelor of Science, 1971
Certified Life Skills Coach, 1974
Certificate in Adult Education, 1979

Work History:

Director
Applied Arts and Health Extension
Red River Community College
1986 to present

Coordinator/Consultant
General Industrial Training Program
Red River Community College
1979 - 1985

Work Experience Coordinator
Human Relations Programs
Red River Community College
1978 -1979

Human Relations Instructor
(Programs for inner-city youth,
post-psychiatric clients, women)
Red River Community College
1976 - 1978

Vocational Rehabilitation Counsellor
Health and Social Services Manitoba
1975 - 1976

Alcoholism Counsellor
Alcoholism Treatment Centre
St. John, New Brunswick
1973 - 1975

Mental Retardation Counsellor II
Dr. W.F. Roberts Hospital School
St. John, New Brunswick
1972 - 1973