DEVELOPMENT DILEMMAS:
THE COMMUNITY HEALTH WORKER PROGRAM
IN NORTHERN SASKATCHEWAN

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ABSTRACT

This thesis presents a case study of the Community Health Worker program and role in northern Saskatchewan, an area of rapid planned change. The role of the Community Health Worker is emergent and innovative and occupies an interface position between dependent and dominant groups, community and bureaucracy, native and white, northern and southern, lay person and professional.

The planned change process in northern Saskatchewan and, in particular, the Community Health Worker program are demonstrated in this thesis to manifest the same basic contradictions and dilemmas which the literature has shown to be characteristic of community work. The contradictions are traced through the context of the program, through the program itself, and through the Community Health Worker's role development.

The research process involved participant observation: extensive observation over a two-year period, semi-structured interviews with program participants, document analysis, introspection and literature review. The data are analyzed qualitatively.

The research is also action research. It is hoped that parts of the research process, i.e., interviews, were clarifying for those involved. The researcher manages a program which includes the Community Health Worker program and therefore has an invaluable opportunity to feed information and insights from this study back into the program where, hopefully, they will be used by program participants in future program planning.

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CHAPTER I

INTRODUCTION

The Community Health Worker (CHW) program was recently initiated in Northern Saskatchewan, an area of rapid change, in order to promote several processes and realize several goals. This program is part of the provincial government's commitment to facilitate and promote northern development. Community Health Workers (CHWs), northern native paraprofessionals who are the central actors in the program, often experience uncertainty, confusion and ambivalence.

The question explored here is: What are the significant factors in the role-set and other contextural aspects of the CHW program which contribute to confusion and ambivalence for a community worker operating at the interface of dominant and dependent segments of a population? Merton (1959) notes that the criteria for determining a significant sociological question or problem is that "answers will confirm, amplify or variously revise some part of what is currently taken as knowledge in the field." I hope that the information and analysis presented in response to the above question confirms the significance of the problem investigated.

A study of the role of the Community Health Worker and the context of the Community Health Worker program provides an opportunity to identify and explore factors which are likely to have impact on role behavior and program process, in this and other programs in similar development situations. The role, the program and the structure in which they operate are clearly at the interface between dominant and dependent segments of a population: southern and northern, provincial

and local government and community, white and native, professional and lay person, service provider and service consumer, perpetuation of the status quo and community development. That interface position is one that is likely to create contradictions, confusion, ambivalence and dilemmas for the occupants. The role as an attempt to achieve several goals at once suffers from a lack of clear emphasis or unifying direction and is fraught with contradictory expectations. Many of these contradictions stem from the nature of the context in which the program was planned and initiated and in which it now operates. The emergent role of the CHW in Northern Saskatchewan is by its innovative nature and its interface position with community and bureaucracy, a clear illustration of a number of these basic contradictions and dilemmas of community work.

A dilemma is a choice or a situation involving choice between equally unsatisfactory alternatives or a problem seemingly incapable of a satisfactory solution. A dilemma exists in the perception of an actor and as such must be recognized to be real. Confusion, contradictions and ambivalence may or may not be accompanied by the perception of a dilemma.

A review of relevant literature will explore community work dilemmas at a conceptual level. The discussion of the empirical reality of the Community Health Worker program will then use the concepts to describe the program and to support my opinion that this program and role are indeed affected by problems widespread in community work. The dilemmas as perceived by actors in different roles in the planned change process may be significantly different but are connected.

This thesis explores the confusion and sociological ambivalence experienced by the Community Health Workers and attempts to make sense

of it through looking at the context-structural, processual and interactional. The discussion will move from the general conceptual framework used to explore and analyse the program and its context to specific empirical data about the context, the program and the role. The focus of the research is wide, encompassing ten health workers in ten northern communities; the analysis is general, seeking understanding of program-wide factors rather than detailed explication of a single case. The analysis explores dilemmas at both the program and the role level. Hopefully the investigation clarifies understanding about the empirical reality of this program as well as reinforcing the usefulness of concepts used by other social scientists and promoting "the discovering of what concepts and hypotheses are relevant for the substantive area being researched." (Glaser and Strauss, 1963, 288)

A combination of extensive observation, semi-structured interviews, document collection and analysis and introspection was used to gain data. I have lived and worked in northern Saskatchewan for almost three years, managing the Health Education program of the Department of Northern Saskatchewan (DNS). This program has, as one of its components, the Community Health Worker program. The combination of a challenging sociological and practical problem with the opportunity for in-depth exploration has been intriguing and exciting. The investigation should be of practical as well as theoretical interest. The CHW program is ongoing. Information gained could be useful to program participants in helping them to define and reach program goals.

Many caring people are involved with the CHW program, itself a part of a context which involves many more concerned, committed people.

They are investing both physical and emotional energy in northern Saskatchewan, their home. A study such as this can focus only on selected aspects of the reality. It is hoped that the description here presented is a fair, sensitive representation.

CHAPTER II

METHODOLOGY - THE RESEARCH PROCESS

The researcher has lived and worked in northern Saskatchewan for almost three years, managing the Health Education program of Health Services Branch, Department of Northern Saskatchewan. Health education activity in northern Saskatchewan has four overlapping components: training, direction and co-ordination of the Community Health Worker program; acquisition, development and distribution of educational materials (e.g., posters, pamphlets, audio-visual presentations); use of northern media for dissemination of health information; and preparation and management of workshops, promotion campaigns, etc. The Community Health Worker program is seen as the most important thrust.

My experiences in northern Saskatchewan and in particular with the Community Health Worker program made me aware of issues important not only to me as a white southerner, but also to northern people. They were issues of perspective and assumption, and of power and control.

By choosing to live and work in the north I had in fact decided to enter a new environment in which I would experience new, often confusing, information and feelings. I tried to keep my eyes and ears - and the space between my ears - open!

I became aware that I was privileged to be witnessing the development of a role, that of Community Health Worker, which in many ways seemed representative of a more general type of role, community worker at the interface between two social systems. In this case one system was white, southern, dominant and professional; the other was native, northern, dependent and composed of lay people. I became

curious about the specifics of that role and the factors which were affecting role development and role behavior.

The first year was a period of developing sensitivity to the issues, after which my observations focused. As issues emerged it became clear that uncertainty and confusion were endemic in the Community Health Worker program. The situation cried out for clarification.

The issues presented themselves as possible dilemmas: goals and assumptions working at cross purposes. Much of the confusion seemed to be connected with lack of awareness of the contradictions on the part of participants. The research process helped clarify and explore the role and role-set as well as the dilemmas, and was a process of identifying emergent issues and progressively redefining the research problem. During the second year, using selected social science concepts and methods, I was able to take a more formalized approach to the investigation.

The methodological approach chosen for this research was participant observation: combining direct observation, semi-structured interviews, document analysis, and introspection. (Bodgen and Taylor, 1975, 4-6). The data are analysed qualitatively.

In Merton's (1959) terms, the 'originating' question of this research was: Is there really as much confusion in the Community Health Worker role and the program as there appears to be and if so from where does it stem? The significance of the question was determined by examining social science literature and concluding that an investigation of the emergent role in its 'development' context (it soon became evident that the role could not meaningfully be described without the context)

would provide empirical data to illustrate several central social science concepts.

Methodology is the way in which the social scientist acts upon the world under investigation. Methodology is dynamic and a part of the research process which cannot be considered or enacted separately from the other elements of research. This is particularly true when the research is intended to have practical as well as theoretical relevance.

The approach chosen to gain meaningful, relevant information must both respect the real world (Blumer, 1969) and be consistent with the values and theoretical orientation of the researcher (Denzin, 1978; Phillips, 1971). Blumer likens research to lifting the veils which obscure the social reality. The veils are diffuse and multi-faceted and the methodological approach must be sensitive and multi-pronged.

In research we use information available from several sources and through different methods. It makes sense to use as many different information gathering methods as is possible and practical. Not only does this provide more data and hopefully a more complete understanding but also a check on the quality and completeness, the validity and reliability of the information. Denzin (1978) and Webb et al. (1971) promote the use of a variety of methods, calling this approach the 'logic of triangulation.'

Daily we receive information from all our senses. On occasion one or more of the senses are relaxed as in sleep; alert, we use sense data available to us. Smelling smoke and hearing a crackling sound confirms the visual impression of fire. But, if, as the flame was approached heat was not felt, assumptions that fire was the cause of

sensations would be challenged. Increasing the types of data facilitates a more complete understanding. Several types were used in this research.

Documents pertaining to the program were collected. They included:

- relevant legislation, i.e., the acts creating the Department of Northern Saskatchewan and the Northern Administrative District;
- DNS publications, i.e., Annual Reports, Public Information Booklet, Five Years After, Budget Speeches;
- DNS Health Services Branch budgets and Treasury Board Submissions;
- internal department and government memos;
- Community Health Worker contracts, draft job descriptions, applicant selection guidelines, application forms and work reports;
- Community Planning Studies, i.e., Buffalo Narrows and La Loche;
- reports by DNS Health Services staff on the progress of the program;
- correspondence;
- Northern Health Association (Buffalo Narrows) 1974 proposal for a native Health Education project;
- northern print media coverage of development and health issues;
- Community Health Worker training materials.

Documents were analysed to identify DNS and Community Health Worker program goals and rationale, and program history and issues in

order to identify expected and actual health worker role behavior.

An interview guide (Appendix A) was prepared. It was designed to glean the perceptions of the program's main actors (CHWs, nurses, local councils) pertaining to: health problems and needs; community members' attitudes towards health and health care; the role of the health worker; program goals, expected program results; and program problems. The interview was used to gather information about the role-set of the health worker by probing the perceptions of the main actors in the program concerning the expectations different people had for health worker role behavior.

Approximately thirty interviews were conducted in ten communities in 1979 during a seven-month period. They were informal and occurred in health centres, cafes, homes, local council offices, at community meetings, in trucks, cars and even aircraft. In some cases it is not meaningful to distinguish between an interview, an observation of an interaction or conversation, or a casual chat. I recorded notes on each occasion, either during the event or as soon as possible thereafter.

People interviewed included approximately half of the DNS nurses and health workers, a physician, five town managers and council administrators and some local council members. I attended council or community meetings at which health services or the Community Health Worker program was discussed in six communities. Observations and conversations occurred with all nurses and health workers in the program. I talked regularly with people in the north about health, the health worker role and program and development issues. I travelled extensively in the area, observing and noting and examining my own feelings and ideas.

Various methodological problems arose. The people interviewed varied considerably in terms of race, facility with English, education, length of residency in northern Saskatchewan and personal history. In some cases information was gained through an interpreter in encounters with people who spoke mostly Cree or Chipewyan. It was impossible to standardize the interactions and thus difficult to classify and standardize the data collected from so many kinds of encounters.

Another problem is that "any case study conducted by one observer can be critically appraised as emotionally biased, perceptually limited, too personal, subjective and ungeneralizable." (McPherson, 1972, 8) I recognize those limitations. However, reality is comprised of all of us acting on emotions, perceptions and assumptions, no matter how structured or 'objective' we attempt to make them. I feel confident that the large amount of information gathered and its degree of consistency contribute to the validity and reliability which may be attributed to any particular piece.

I cannot identify and delineate the observer and interviewer effect I undoubtedly had. As a manager of and participant in the program I have been influential. However, so have many others. The number of program participants, occupying various roles in a complex structure, diffuses the effect of any one participant. I will continue to influence the program, and intend to share the ideas I have formulated during this process in order to continue the research-action.

One of the things I had to confront was that it was important that the thesis-related aspect of the research be unobtrusive. Many people, particularly in northern Saskatchewan, are suspicious of

researchers. This attitude seems based on a lack of understanding, or more probably a perception that they have been "used" previously solely to meet outsiders' needs. Information from much research activity in northern Saskatchewan has not been shared widely.

My job role (Senior Health Educator) necessitates continued interaction with the people involved with the Community Health Worker program. It would have been irresponsible for me to risk straining the normal relationships or injecting a possible problem into information gleaning activities.

Throughout the research the following dictum by Denzin was respected: "... observers should not try to present themselves as something they are not and should use to advantage all the personal characteristics they possess to enhance the observational role." (1978, 186) I was eager to learn people's perceptions of the program's goals, structures, and roles and how these fit with community needs and patterns. I spoke honestly of using the information for program planning, health worker training, and development of a health worker job description. In most cases reference to the thesis was not made. It was not, however, a secret. My supervisor,* and co-workers knew but I often chose not to draw attention to the fact.

I experienced uncertainty and anxiety about this course of action but it seemed the most prudent thing to do. I felt confident that my observations, interviews, and involvement would contribute clarification for program participants, as well as provide data for a thesis. I considered the process to be action research.

Action research (Lewin, 1947) or as Sanford (1970) says

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* DNS Health Services Branch Director has been my supervisor in the absence since May 1978 of an Assistant Director.

'research-action' is in process as well as product an activity which is used by those involved to plan and solve problems. For Lewin, action research is a spiral of activity consisting of analysis, fact-finding, conceptualization, planning, execution, and more fact-finding or evaluation. For Sanford, the process involves analysis, fact-finding, and planning. He notes that planning does not play as important a part in his model because the planning best happens with the people actually involved in and affected by each study.

Earlier I stated that the researcher's methods are a form of interaction and action. They are rarely truly unobtrusive. When possible they might as well contribute positively to the social reality. Sanford's statement rings true for me: "most social science questions, in my view, should be of this general kind: how to arrange the environment, institution or the social setting in such a way to promote the development of all the individuals concerned." (1970, 14)

Research interventions can promote both theoretical development and action for human development. That has been the goal in this research. I wanted to gain information in order to understand fully the complex role-set of front-line community workers as they create a role which is new to their communities. It was important to me as well to feed that increased understanding back into the system so that the information would be of practical value.

The process of the research activity has for me been like the analogy developed by Schutz (1967) to describe group process. When a person changes a tire on a car they place the tire on the rim and then lightly tighten the bolts. The bolts are sequentially tightened. One

bolt is not completely tightened and then the rest for that might adversely affect the balance of the tire on the rim. In this research process information on a number of areas was received and digested, bit by bit. One aspect did not finish and then another start. The bolts were tightened slowly and in co-ordination.

This analysis represents my thoughts and the statements of others, at this point in time. It is hoped the effort will increase understanding about the Community Health Worker role and program, northern Saskatchewan and community development, as well as promote constructive action.

The product could continue to be revised, probably indefinitely. However, for now the wheel in Schutz's analogy is on the rim with enough stability to be meaningful and useful.

CHAPTER III

THEORETICAL AND CONCEPTUAL FRAMEWORK

Discussion

Much social science literature analyzes the dynamics of planned change processes involving population segments with unequal power. In this chapter a theoretical framework using concepts from several areas of sociology is presented. The bolt tightening analogy has relevance for describing the process of the development of the conceptual approach. The literature is vast. The ideas here presented are the ones which have remained meaningful and useful to me in exploring and describing this particular social reality.

A central theme is the interrelationship of a social actor and her/his social environment. Watson and Johnson (1972) stress that structure, process and attitude must be considered in seeking to understand a change process. They state:

> A social system having a certain pattern of structure establishes positions with prescribed roles. In the process of carrying out these roles, individuals develop corresponding outlooks, attitudes, and feelings. A change in the system brings changes in positions and roles and the changed interaction alters the way participants are feeling. (200)

Watson and Johnson's work identifies the influence of structural factors on role behavior and directs attention to the importance of planning and developing structures which will foster rather than inhibit the desired processes and attitudes.

In situations where there is an obvious power imbalance between identifiable groups of people the power or lack of it can be viewed as

the central change issue. The structures which serve the enabling mechanisms for change either overtly or covertly influence the way in which power will be distributed during the change process.

Planned change does not occur in a vacuum. "Most change efforts intervene in an already changing situation so the problem is not to bring about change, but to bring about a certain kind of change." (Warren, 1977, 17)

The processes and desired outcomes of any planned change process when two groups, dominant and dependent, are involved can be usefully classified as assimilation, separation, integration, or accommodation. (Swenson, 1978, 11-15)

Assimilation is the process whereby the dependent group accepts the values and goals of the dominant group. No change is required from those dominant, but those dependent must change to be like the others. Separation is the process whereby each group chooses and works independently towards different goals. Integration is the process whereby both groups agree on the same goals and collaborate to work towards them. One has integration rather than assimilation when the dependent group freely chooses the values and goals in the system of which they become a part. With assimilation they accept them, they do not choose them. With integration the power imbalance between dominant and dependent is somewhat redressed because the dependent group has the power and ability to make choices but the dependent group still changes more than the dominant. Accommodation, like separation, is a process whereby each group chooses and works towards its own separate goals, but differs in that the two groups co-operate during the process of pursuing these goals.

The interaction between the dominant and dependent groups can take one or a combination of three forms and influences which of the above conditions occur.

1) The dominant group can act on the dependent group by developing and implementing programs. The dependent target population then reacts to these programs. This arrangement does not involve a change in the locus of power and is less likely to promote a change in behavior in the dependent group since they have no involvement in planning or implementing the program and therefore less stake in it. The goal is provision of services to people who are perceived to need them. This is one type of social planning (Rothman, 1968, 20-36) in which the 'experts' plan and guide the change process. This process may lead to assimilation as the consumers of the service remain powerless.

2) The dependent group can act, as in confrontation or revolution, and the dominant group react. Rothman calls this 'social action.' It is the type of planned social change best known through the work of Saul Alinsky (1972). It aims at making basic changes in major institutions or community practices by organizing the disadvantaged or dependent segment of the population to make demands on the larger community. Successful social action* may result in separation or accommodation. The dependent or disadvantaged group is taking control over their direction.

3) Joint planning and implementation of programs may occur with members from the dominant and dependent groups both acting and reacting. The process of change as well as the outcome are central concerns.

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* In Canada the social action process has been documented by H. Buchbinder and B. Carniol in B. Wharf, ed., 1979 and by the National Council of Welfare-Ottawa 1975 among others.

Shared social planning may occur where process and outcome receive equal attention, what Rothman calls 'locality development', in which the importance of the process of self-help, voluntary co-operation, and developing indigenous leadership is paramount. The product outcome is not defined. The assumption is that if people become organized they will define goals and services to meet their needs.

Shared social planning and locality development assume citizen or service consumer active participation. Social planning of this sort is likely to result in integration, and locality development in either integration or accommodation.

It is clear that while much in a change process is serendipitous there are foreseeable connections between approaches and likely outcomes. Clearly defining the problem that an approach is intended to ameliorate will greatly facilitate making an informed choice of a reasoned plan. The unequal power distribution between dominant and dependent groups has been often identified as a problem in planned change processes. Ryan (1976) reiterates Gans' succinct appraisal. "The primary cause of social problems is powerlessness. The cure for powerlessness is power." (25)

Dependency is a hard syndrome to shake. There is a large body of literature (particularly Adams, 1975; Freire, 1970; Lloyd, 1967; Roberts, 1979) which stresses that the dependent groups must themselves make the changes in their self-concept and patterns of organization, and then struggle for power. As long as service and self-concept are being given, instead of chosen and taken, the people will remain dependent and powerless.

The general approach to community intervention which most overtly recognizes power as the issue is that of community development. Its central theme is "the organization of people in a locality to deal themselves with problems and opportunities close at hand that affect their lives and patterns of living." (Cary, 1970, 1)

Community development has been defined many ways. This author borrows a definition from the United States government:

> "A process of social action in which people of a community organize themselves for planning and action; define their common and individual needs and problems; make group and individual plans to meet their needs and solve their problems; execute these plans with a maximum reliance upon community resources; and supplement these resources when necessary with services and materials from governmental and non-governmental agencies outside the community." (International Cooperation Administration, 1956, in Cary, ed., 1970, 19)"

The approach known as community development has grown out of a union of community organization (stressing local action and local resources) and economic development (emphasizing planning and systematic movement toward defined goals). (Sanders, 1970, 9-18) The process often focuses either on the development of community through enhancing opportunities for individuals to grow and be more proactive or on supporting more visible community structures such as economic development enterprises.

Community development as here outlined is one problem-solving option* when the goal is to redress power imbalance between dominant

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* Legal or legislative reform also addresses power issues, but from an external rather than a self-help perspective.

and dependent* groups in a society or community. This orientation to community development focuses on the process of people taking the power to define and identify solutions for their problems. The way the problems are defined and the action the people take to solve them are determined by the participants in the process.

An analysis of the causes of social problems (and the resultant directions for action) may well focus on issues other than power. For example, different assumptions are made about the role of individuals or social structures in causing or contributing to social problems.

Ryan (1976) has suggested the dimension of 'exceptionalism'/'universalism' as an ideological underpinning for these two contrasting approaches to the analysis and solution of social problems.** Exceptionalism focuses on the individual as the source of the problem. Within this belief, the "formula for action becomes extraordinarily simple: change the victim," and the planning focuses on changing individuals. (Ryan, 1976, 8) Universalism identifies:

> "social problems are a function of the social arrangements of the community or the society and that, since these social arrangements are quite imperfect and inequitable, such problems are both predictable and, more important, preventable through public action." (Ryan, 1976, 18)

Ryan suggests that the exceptionalistic idea has been internalized by many well-meaning people and resulted in a syndrome which he labels "blaming the victim." He notes: "It is brilliant ideology for justifying a perverse form of social action designed to change,

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* Individuals may be in a state of relative dominance and dependence. A local elected representative may experience dominance in the community and also be a member of a dependent segment of the population. This idea will be developed in the next chapter.

** Ryan (1976) notes that others have developed similar categorization schemes particularly Warren, 1971; Hoshino, 1969; and Titmuss, 1975.

not society, as one might expect, but rather society's victim." (Ryan, 1976, 8)

The nature of assumptions is that they are often not recognized as such unless somehow challenged. Examining assumptions can reveal the root of contradictions which may be reflected in people's experience as stress, confusion, and/or dilemmas.

As we have pointed out, in a planned change process the interrelationships between structure, process, and attitude warrant attention. Lack of awareness of the connections may confuse or thwart the process of change. Planned change which involves identifiable population groups in a dominancy-dependency relationship is often intended to change the power balance. Both the outcomes of the process (Swenson) and the structures, approach and the locus of control in the process (Rothman) are influenced by assumptions about what the problem is, why it exists, whose problem it is, and who should have the power and ability to direct and make the changes.

One set of assumptions leads to the approach known as community development which stresses the importance of problem identification, planning, action and resource management being done by those who will be affected by the change process. Since the issues are power and control the focus is on process, for it is through action that people take personal power and responsibility.

If one accepts power as the central issue and adopts a community development perspective or approach, then the choices about change process and desired outcomes become the responsibility of the community members. They may choose separation, integration, or

accommodation; may define their problems universalistically and/or exceptionalistically; and may work at solutions through shared social planning, social action, or locality development.

In keeping with the community development approach, it is becoming common for organizations seeking change to use local non-professional workers as change agents. This is particularly true in the health field. These people become the liaisons between the dominant and dependent segments, the professionals or experts and the consumers. They are the interface.

Concepts useful in describing the empirical reality of the Community Health Workers' experience are drawn from role theory. Roles are one of the cornerstones of the social reality we create, for they provide a framework for our expectations of ourselves and others. Roles are dynamic and thus defy definitive description. They can be explored, however.

The concept of role is an important one for the social sciences. It is a central and unifying concept because it focuses on the merging of the individual with the social and of the structure with the process.

Insights gained through research into roles in localized contexts are often generalizable. Specifics of role behavior vary greatly but general influences such as power, support, structure, expectations, goals and self-concept can be seen consistently to have impact on role development.

'Role' is used herein to mean "normatively patterned action of social actors" (Weber, 1946, 583). The concept of 'role' is most

useful when considered as part of a 'role-set' or "that complement of role relationships which persons have by virtue of occupying a particular social status" (Merton, 1957, 369). The way individuals in the role behave is partly a combination of their perceptions of themselves, and their perceptions of the expectations of significant others. Symbolic interactionists (Cooley, 1964; Mead, 1962; Blumer, 1969; Goffman, 1967); phenomenologists (Schutz, 1962) and theorists in the sociology of knowledge (Berger & Luckman, 1966) stress that social reality is created by each individual in interaction with his/her environment.

Neither the individual, nor the environment, nor the role, is static. "The role set is no unified, smoothly functioning guide for performance, but rather a cluster of changing, often conflicting pressures." (McPherson, 1972, 8-9)

These conflicting pressures may result in 'sociological ambivalence (Merton & Barber, 1963) where ambivalence comes to be built into the structure of social statuses and roles. In the most restricted sense, sociological ambivalence is incompatible normative expectations incorporated in a single role of a single social status. In the most extended sense it is incompatible normative expectations of attitudes, beliefs and behavior assigned to a status or a set of statuses (94-95). This concept is important here for as Merton and Barber note the idea of sociological ambivalence directs us to examine the processes in social structure that affect the probability of ambivalence turning up in particular kinds of role relations.

Conclusions

The concepts discussed above introduce several contradictions inherent in many planned change processes. If the primary cause of many social problems is powerlessness then the cure is power. However, as Goulet (1971) remarks:

> "...the prevalent emotion of underdevelopment is a sense of personal and societal impotence in the face of disease and death, of confusion and ignorance as one gropes to understand change, of servility toward men whose decisions govern the course of events..." (23)

Dependence may be perpetuated because people who think of themselves as powerless do not have the power to take power. Also, if one's basic needs are not met one is unlikely to direct energy to redressing a power imbalance.

Goals may be set and planning managed either by the dominant group as in social planning or the dependent group as in community or 'locality development' and 'social action.' Freire (1970) describes how the dominant group is likely to be structurally and perceptually unable to manage the change so that power shifts away from them. Ryan (1976) argues that the 'Blaming the Victim' syndrome can result from the dominant group's genuine humanitarian interest in helping people seen as disadvantaged. The dominant group, however, with the confidence that stems from successful domination, tend to think they have the answers. They are not likely to work actively to change societal structures which are supporting their lifestyle. The concept of self-help and local control can easily become buried in the push to change the people, to make them catch up. Product rather than process becomes the goal.

Freire discusses how the dependent group (his terms are oppressors and oppressed) are likely to define their goals in terms of being like those who are presently dominant. This may lead participants in a community development process to seek integration as well as or rather than accommodation and to define their problems in an exceptionalistic as well as or rather than in a universalistic framework.

It is probable that integration and exceptionalism will be part of the approach and the goal, whoever is managing the change process. In fact, accommodation and universalism are perhaps more likely to be overtly recognized as desirable if the planning involves people who have enjoyed dominance and who, therefore, have had the luxury to ponder social issues. Often well-meaning planners and developers will attempt to promote accommodation and universalism with people who define their needs exceptionalistically and perceive their goal to be integration.

Often programs attempt to promote both integration and accommodation and to provide both exceptionalistic and universalistic services, to kill as many birds as possible with one stone. As has been discussed here, however, the approaches are significantly different in process and in outcome and may in fact be contradictory. Perlman and Gurin note that historically there have been two dominant themes in community work: "strengthening social provisions and improving people's problem-solving capacities and relationships." (1972, 37)

Stinson (1979) identifies this problem in his analysis of the North Frontenac Community Services Centre. "The root of the difficulty centred on the mixture of two concepts, service delivery and community development, in a deprived rural area." (98)

When the concepts and goals are mixed the actors in the change process may experience a dilemma. Cox (1970) notes:

> "One dilemma in community organization...is whether community intervention should stress the delivery of services to individuals in need or the modification of social conditions which predispose some people to dysfunction or disadvantage." (5)

The description of the situation in northern Saskatchewan, the Community Health Worker program and the Community Health Worker role will demonstrate to what extent these contradictions and dilemmas have indeed been part of the program. The central dilemma has implications in program structure and process and affects the feelings and role behavior of the Community Health Workers themselves.

CHAPTER IV

THE CONTEXT

Northern Saskatchewan is an area of planned change and rapid development. The provincial government formalized a northern region with the Northern Administrative Act of 1972. A zig-zag line at approximately the 54th parallel divides the province into rough halves (see map - Appendix B).

Northern Saskatchewan is 96,250 square miles of trees, lakes, rivers, and rocks. The area is home to approximately 30,000 people, mostly of Indian (Cree or Chipewyan) ancestry. The population can be divided roughly into thirds - 10,433 Treaty Indians, 10,457 native or Metis, and 7,266 white. Demographic data are unreliable due to the high number of transients and frequent migration of groups of people for trapping, fishing, construction and mining. Department of Northern Saskatchewan publications indicate that the white population resides mainly in the area's three largest centres: La Ronge, Creighton, and Uranium City. These larger communities are historically centres of mining operations. Creighton and Uranium City remain so today.

There are forty-six communities in the North ranging in age from Cumberland House, established during the fur trade era in 1774, to Weyakwin and Southend Reindeer, new communities established in the mid-1970's. Community size ranges from fifty to three thousand people with a mode size of seven to eight hundred people. All communities are located on water, the natural transportation system of early days, and still much in use today. (Cotterill & Myers, 1976, 3)

The area was originally populated by Indians whose traditional pursuits were hunting, trapping and fishing. Europeans first entered the area as fur traders, explorers, and missionaries. Thus began the exploitation and colonization of the area and the people which have continued for over two hundred years. Hopefully, that tide is being stemmed and turned as northerners take more control over their lives and political structures.

Today, economic pursuits include the traditional ones and/or forestry, mining (zinc, copper, uranium, limestone), tourism, construction, limited agriculture, and limited service industry. Much of the employment is seasonal and there is much unemployment.

The standard of living, as indicated by the ease of meeting basic needs such as food and shelter and accessibility to services, was and still is, much lower than that enjoyed by most of the province's people. The area exhibits a high birth rate, high disease and high infant mortality rates, low incomes, limited education and it receives large amounts of economic aid. As the following table demonstrates, in 1968 the birth rate in northern Saskatchewan was almost twice the provincial average and the infant mortality rate was fifty-seven percent higher than the rest of the province. (Federal Provincial Task Force on Northern Saskatchewan)

TABLE 1

VITAL STATISTICS 1968

	North Sask.	Sask.	Canada	Japan	China	India	World
Birth Rate*	37.1%	18.8%	18.2%	17.0%	43.0%	41.0%	34.0%
Infant Mortality Rate*	60.2%	25.8%	22.9%	19.3%	n/a	72.8%	n/a
Death Rate*	6.7%	7.8%	7.4%	6.7%	n/a	8.2%	n/a
Growth Rate**	7.0%	1.0%	2.2%	1.0%	1.5%	2.3%	2.0%

* rate per thousand

** annual percentage increase

While improving, the health status of northern Saskatchewan residents is still poor. In 1974 the birth rate was the highest in the province (21.1 per 1,000 population), the infant mortality rate the highest (40.1 per 1,000 live births), the natural increase rate the highest (16.8 per 1,000), and the stillbirth rate the highest (15.7 per 1,000 live births).*

The death rate for the northern area was the lowest in the province (4.2 per 1,000), reflecting the fact that seriously ill people are sent to southern Saskatchewan or Manitoba hospitals. However, it is notable that in 1974, 21.7% of all deaths in the area are reported as being due to accidents, whereas in Regina that year the percentage was 7.3%.

It is difficult to find valid data on disease rates as much of the treatment in the north is provided by government nurses (provincial

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* Saskatchewan Vital Statistics, 1974 Annual Report

and federal) and each agency has a separate reporting system. Also, many northern residents seek hospitalization, physician services, dental care, etc. outside of the area because of personal choice, proximity of service, or necessity.

Some figures are available, however. In 1977, approximately 3% of the total provincial population lived in northern Saskatchewan, yet 26% of the reported venereal disease cases in the province were recorded in the north and 12.2% of all infant deaths. It seems safe to conclude that northern Saskatchewan residents do not enjoy the same standard of health as most people in the south.

People in the area are still relatively isolated by southern standards although roads and airstrips have been improved and extended, housing has been upgraded, and communications systems, i.e., phones, radios, television, are now found in almost all communities. These modernization activities have provided some employment opportunities for northerners, albeit often short term and seasonal.

Today, exploration, mining, and milling of minerals, particularly uranium, is providing some employment and fuel for northern employment issues. Northern people are becoming organized to make their claim for a slice of the jobs and other benefits of the uranium industry.

The Department of Northern Saskatchewan (DNS)

The fact that the social and economic needs in northern Saskatchewan were not being adequately met was confirmed in analyses conducted by provincial government consultants in the late 1950's and 1960's. A consolidation of the provincial government's approach in

meeting these needs was recommended.*

In May 1972, the Department of Northern Saskatchewan was established. Its mandate was the delivery of almost all provincial services in the north. The headquarters of the new department were located in La Ronge with regional offices in other larger northern communities.

This provincial department is unique within Canada. Its mandate was to improve co-ordination of provincial services by making all northern services responsible to a single cabinet minister, and thus creating a single agency with branches corresponding to southern departments (e.g., Social Services, Health, Resources, Economic Development). Locating the headquarters in the region to be served was intended to make the department more accessible and responsive to the people of the north, and enable it to be a catalyst for northern development by northern people.

The original proposal for the single agency outlines four major goals: a comprehensive approach, sensitivity to the needs of individuals, smooth delivery of services, and co-ordinated communications. (Myers, 1978, 1)

The intention was to increase involvement by northerners in

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* Services for treaty Indians and reserve communities are the responsibility of the Federal Government,Department of Indian Affairs and Northern Development and National Health and Welfare, Medical Services. Details of service delivery are co-ordinated between DNS branches, e.g., Health Services and the Federal counterpart (Medical Services). In general, those communities with a population of mostly treaty 'Indians' are served by the Federal government and mostly Metis or 'white' people by the province. Some centres have both offices.

government, both at the local level through creation and support of municipal councils, and at the provincial level by hiring northerners as DNS staff.

DNS is the most pervasive organization in northern Saskatchewan. To a large extent it controls the purse strings in the area whether through economic development loans, social assistance, or monitoring northern employers to assure the agreed upon quotas of northerners are employed. DNS controls leases and monitors quotas for natural resources, e.g., commercial fishing. It funds or directly provides school and adult education opportunities. It employs many people. The list is long.

Why does DNS exist? No other province has a comparable department. There are many possible reasons. A sceptical view is that the provincial cabinet knew there was uranium in the area and wanted to modernize the north so as to make uranium mining appear less exploitive. Another view is that the provincial government has a real commitment to sharing goods and services with all provincial residents and thus chose to invest considerable money and energy in order to put their philosophy into action. The truth is probably a combination of these views.

It is not my intent to evaluate DNS. There may have been as many different reasons for supporting its creation as there were people involved in the process. There are also many different angles from which to judge whether it had and is having a helpful or harmful effect on northern Saskatchewan people. It does seem evident that people from the south would have come north after the minerals and/or lifestyle anyway. DNS has promoted more rapid change than would likely have occurred

without it and that change has contributed to social disorganization. DNS staff have made many mistakes. DNS has also contributed to political awareness and activity. Are disorganization and the beginnings of political activity preferable to being left alone with few services and high disease rates? The issues are extensive.

What did DNS record that it was there to do? In 1972, at its inception, the goals were stated as:

1. Improvement of living conditions in the north, in accordance with the wishes of the people of the north;
2. Accelerating political, economic and social development in order to bring the services and standards to a level comparable though not necessarily identical with those of the south.
3. Removing northern communities from a syndrome of dependency, and substituting a situation in which northern people become independent decision-makers, and inter-dependent with other levels of government;
4. Government inputs geared to getting northern people involved as decision-making, problem-solving participants at all levels;
5. A single agency personnel with the role of facilitating the implementation of programs which are decided upon by the northern communities through the various councils (instead of the traditional role of implementing programs passed down from the government);
6. Combined community and government inputs of the single agency able to give fullest recognition to the needs of the north and to the necessity for novel solutions;

7. Leaving behind a north which, from an administrative and economic point of view, is integrated with the south, and which, from a cultural and social viewpoint, maintains its integrity and uniqueness. (Bowerman, 1972)

It was intended that the DNS would self-liquidate when services and standards in the north were at a comparable, although not necessarily identical, level with those of the south.

Several themes or concepts are highlighted in these statements. The most prominent is the commitment to strengthen northerners' involvement in the self-governing process through local decision-making. Inherent is the belief that real options exist. The statements of the Minister stress that the provincial government supports the development of "services and standards" and "programs" which are different from those in the south, and "novel solutions" chosen by the people. These possibilities must exist for the government intervention to be considered 'community development.' "It is of little use to control something that is coming into a neighborhood if the shut-off valve is outside the neighborhood and controlled by someone else." (Ryan, 1976, 336) It must be true, and be seen to be true, that there is something for northerners to gain by investing energy; that the products as well as the process of their involvement in organized activity demonstrate autonomy.

It seems that the stated goals of the provincial government were to promote integration in northern Saskatchewan at the administrative and economic levels, and accommodation at the cultural and social levels. As long as the northern systems and structures were integrated

with southern ones (the rationale and mechanism established for revenues from uranium and other monies such as taxes going back to provincial coffers), then the government seemed prepared to support cultural and social systems different from those in the south.

The central contradiction and possible dilemma identified in the previous chapter is built into the goals of the DNS. Not only are integration and accommodation both pursued but also provision of services to people with problems (exceptionalism) and promotion of changes in the social structures (universalism). The attempt to realize dual goals causes confusion unless it is very clear which goal is being pursued through which structures and processes. Attempting to reach contradictory goals through a single intervention, e.g., the Community Health Worker program, is likely to lead to lack of any shared emphasis.

Factors in the Effectiveness of the Department of Northern Saskatchewan as a Development Process Catalyst

Agencies pursue their goals through the development and implementation of policies. Policy has been defined as "an articulate and relatively stable theory of how to cope with a certain problem, based on certain beliefs about the nature of the world." (Wallace, 1976, 5) Etzioni distinguished between fundamental and incremental policy making processes. Fundamental decisions are made by

> "exploring the main alternatives the actor sees in view of this conception of goals but... details and specifications are omitted so that an overview is possible. Incremental decisions are made, but within the contexts set by fundamental decisions and fundamental reviews." (Etzioni, 1968, 388)

In this discussion the distinction between fundamental and

incremental is important because the proliferation of incremental decisions and the dualities of the fundamental policy contributes to the confusion which has often pervaded the health workers' role and the Community Health Worker program.

Etzioni points out that many policy-related decisions occur without the decision makers and actors considering the total picture. The overview is not part of everyone's reality. It is questionable that it can be. Lindblom (1970) observes that, although the ideal in policy formation and planning is to tackle each issue with a complete problem-solving system which he terms the root approach, this is often not possible or practical. More often the so-called branch approach is used. This involves making assumptions using only that information which is available. Gaining support for the proposed policy from those needed to finance and implement it is often the determining factor. (Lindblom, 1970, 291-301)

Lindblom's classification of 'root' and branch' decision making styles, while useful, needs to be viewed more as a continuum. Practicality precludes researching all possibilities, but investing time in complete definition is crucial to reasoned, effective problem solving. Etzioni (1968) refers to the process of reviewing and reaffirming or changing fundamental ideas while taking action in some areas as mixed scanning. It is parallel to the meshing of theory and research discussed particularly by Denzin (1978), Blumer (1969), Glaser and Strauss (1967), and acted on by Garfinkle (1967) and Becker (1953) among others, where the theory and the research affect each other.

Another policy-making and planning approach recognizes that goals may be uncertain, unclear, or changing. McNiven (1979) comments on 'adaptive planning' as:

> "an attempt to create adaptive social organizations capable of continuous learning. It emphasizes the importance of a proactivist attitude (making it happen) and of assuming active roles to bring about a future chosen as desirable. It also asserts the necessity of multiple interest groups involvement to ensure implementation and of feedback for assessment and self-correction." (220-221)

It is much easier to have a collective approach to goal setting, policy making and planning in small organizations. In fact, McNiven (1979) comments that the Vancouver Social Planning Department has deliberately kept itself small in order to maintain cohesiveness.

DNS is large with approximately fifteen hundred staff in 1978. For staff to have any shared idea of goals or plans is obviously an organizational challenge. It must be done, however, if the development goals of the department are to be meaningfully translated into action.

It is the supervisory and field level staff whose job it is to implement programs, including the health worker program. They make the day-to-day decisions and take action which largely determine the reality of the program. Social psychology, particularly symbolic interactionism, tells us that decisions and actions are a result of the interplay of several factors: who the people are; what they perceive the means and goals to be; what they define the possibilities to be in the environment, and how they react to that environment. If a policy is clearly and consistently communicated and understood it can become part of people's frame of reference. However, DNS in general and Health Services in particular have not experienced consistent leadership. Since 1972, there have been three ministers, six deputy ministers (some in acting capacity for short periods); four assistant deputy ministers of the sector to which Health is attached; three Health branch directors,

and vacancies and people filling in for short periods as assistant director. During the period of this research the Community Health Worker program and the nursing program have had the same manager, but the staff in the programs have changed.

Changes in personnel do not necessarily mean changes have occurred in fundamental policies. These may have been expressed erratically with changing emphasis. Incremental decisions on the other hand are less likely to have been consistent.

Most of the DNS staff, especially those in supervisory and management roles, are white southerners.* DNS is committed to hiring native staff but the ratio is still unbalanced. One block to hiring more native northerners is the concern by DNS that people be "qualified" and if possible, "experienced." DNS does not want to plan for employee or program failures! Few northerners have chosen to move south to get a formal education. DNS has given special consideration (in terms of Public Service Commission standards) to related experience, but this does not solve the problem since opportunities to gain employment

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* In December 1978 DNS records show:

Code A	Executive	24 employees	no native	or	0%
Code B	Management	77 employees	7 native	or	9%
Code C	Supervisory	180 employees	37 native	or	20.5%
Code D	Clerical & Administrative	268 employees	54 native	or	20.1%
Code E	Labour	454 employees	344 native	or	75.7%
Code F	Professional	73 employees	4 native	or	5.4%
Code G	Para Professional & Technical	346 employees	162 native	or	46.8%
Code H	Tradesmen	102 employees	13 native	or	12.7%

experience in the north have been so limited.

The judgement about qualified or non-qualified is of course made within a standard southern frame of reference. La Rusic (1976) has challenged the implicit assumption in this judgement. He notes examples: the staff of the Quebec Crees following the James Bay settlement, who were 'untrained' and 'inexperienced' yet worked well to develop and implement policy.

> "It would seem that it would be well to question the whole matter of levels of experience and formal training expected or demanded at the middle or senior levels of bureaucracies...the Cree experience would indicate that either the present government standards are too rigid or that there is an enormous untapped potential in personal development in a situaion where highly committed people are motivated by ideals of service to community." (La Rusic, 1976, 39,40)

For whatever reasons, most DNS staff remain southerners and white. Those that do not fall into these categories have few role models. The ideal framework of what could or should be is, for most people, defined in terms of systems with which they are familiar. What seems reasonable supplants what is possible as a paradigm because assumptions leading to incremental decisions are often made without people realizing the nature of their assumptions.

Ethnocentrism influencing incremental decisions is not the only block in the development process. It is coupled with a resistance to change experienced by participants in the process.

Once any action is taken, services and structures develop. As these take shape, however formative, the people involved have a personal investment in them. Unless they perceive a good reason for change, people will work to perpetuate and support that which they have had a

role in creating. In an innovative, developmental situation care must be taken to ensure consistency between goals and structures and a concerted effort must be made to communicate that consistency to the participants early enough to influence their perceptions, decisions and behavior.

Local Government in Northern Saskatchewan

Formalized and functioning local government is an integral component in the present federal, provincial and municipal government systems. Local government in northern Saskatchewan includes: Local Community Authorities (LCA) having the authority to handle financial agreements and pass by-laws; Local Advisory Councils (LAC) found in smaller communities acting in an advisory capacity only; and the Northern Municipal Council (NMC), the legal co-ordinating body for the Local Advisory Councils.

Support and promotion of local government is a cornerstone in the philosophy of DNS. Effective local councils, levying taxes and managing services, can be integrated into the existing provincial system. As well, local government is a mechanism for community organization, development and control. Both integration and accommodation are supported through promotion of local government and once again two goals are being sought through one process.

How effective are local governments as agents for community organization and development in northern Saskatchewan? Do they represent their respective communities?

Haggstrom (1970) distinguishes the 'acting community' as

those people or agencies who regularly or from time to time exert direct influence in decision-making which affects the community as a whole. The acting community engages in collective action and community decision-making. Since the acting community has the power it may or may not take action consistent with the wishes of those who are not participating. Not all people in every community enter the acting community.

In northern Saskatchewan the formal acting community is emerging. It includes: local government councils, native women organizations; the Association for Metis and Non-Status Indians; local boards and committees; such as day care, school boards, and recreation; Indian band chiefs and councils and boards/committees; and DNS staff. People involved in any one of these groups may also be involved in one or more of the others. This is often the case.

La Rusic (1976) says that when a community is in transition from a land based to a wage-labour economy (as happens in most northern Saskatchewan communities), "the better hunters tend to be the ones to first get involved in wage labour." (16) Community leaders tend to involve themselves in the acting community thus creating its structure even, or more particularly, when in transition.

The Buffalo Narrows Planning Study (Amisk Planning Consultants, 1978) reports that eighty percent of the residents of Buffalo Narrows did not know what happens at an LCA meeting and said they felt they had no influence on decisicns about the community. Thirty-seven percent of people surveyed knew the names of the LCA councillors, thirty-seven percent knew no names.

The authors of that study suggest that "the apparent apathy on the part of the community residents may be more a result of limited information and few opportunities to become involved." (45) In northern communities, until very recently, word of mouth was the only method for local news transmission. This procedure was probably quite effective historically. At least it was accepted as viable. Now, however, the population is becoming more and more literate. They are starting to have a written history. Yet the news of public and agency meetings still travels only by word of mouth. In this situation it is difficult for receivers of information to check the truth or reliability of this information. As the Amisk Planning Consultants state:

> "People are poorly informed and learn of most local news via word of mouth, at best an imprecise means of information which leads to distortion and confusion over issues, and which makes co-operative community action difficult. Communication is poor between the LCA and the community." (45)

Two major varieties of community development are identified by Haggstrom (1970). One can either focus on strengthening the visible dimensions of the community or one can focus on facilitating the development and migration of marginal groups into the 'acting community.' The latter is essential if the goal is sharing power and increasing power for people caught in a dependency syndrome.

In northern Saskatchewan the acting community seems to comprise a relatively small percentage of the population. The communities are in transition from a land based to wage based economy, and from dependent to more proactive. The same people are often functioning in several roles in the acting community. They are forming a dominant

group in relation to other community members.

Warren (1977) recognized that

> "much of what is called community decision making and community change is actually the decision making or change that is brought about by or in a single identifiable formal organization." (15)

Limiting attention to strengthening the acting community is risking supporting and perpetuating an established elite. Adams (1975) castigates native organizations and leaders for their concern with perpetuating their own status rather than really working for the people.

Much DNS activity and attention is being focused on local councils which are being primed for an organic(Durkheim, 1933) complex system. They are learning about taxes, housing, budgeting, grantsmanship, surveying, sewer and water systems, etc. LCA meetings are lengthy and usually have a packed agenda. Often there is no time to ponder basic community development issues. Councils are trying to learn the rules of the game they are playing!

Currently the NMC/LCAs/LACs are the most encompassing formal voice for the people. They are working hard, and are trying to help their communities. They are logical contacts for DNS staff and programs and in a democratic system they must be supported.

That support makes sense ethically and practically. Gandy & Delaney (1977) emphasize this fact:

> "In Quebec regionalization has effectively bypassed the local political structure which is probably a contributing factor to the continued concentration of decision-making at the provincial level." (116)

That is not the only practical concern. Wharf (1979) comments also:

> "It seems clear not only from Quebec, but from B.C. and the U.S. 'war on povery' that municipal political structures cannot be bypassed if local level human service organizations are to be developed. Reforms which seek to exclude the established political structure will be substantially sabotaged or destroyed." (263)

It is not reasonable, however, to expect more from the NMC/LCAs/LACs than they are able to do. The LCA is not the community! If facilitation of individual grass roots involvement and control is also a goal - 'curing powerlessness' - then the LCAs are not the only focus for development activity. Organization of other groups must be supported.

Conclusion

In northern Saskatchewan identifiable groups are engaged in a planned change process: the provincial government through DNS, the local government councils and other organized groups in communities, and the general populace. The interplay is complex. The goals of these groups may be internally contradictory as well as similar or different from the goals of the other groups. The dominancy-dependency relationships are also complex because the 'acting community' is both dominant in its community and dependent in terms of the provincial society.

DNS goals indicate support for both integration and accommodation, and for exceptionalistic services and universalistic structural development. The decision-making processes which occur within the department and the orientation of most DNS staff tend to promote integration over accommodation and exceptionalism over universalism.

Local council members and to some extent other members of the

'acting community' become a dominant sub-group of a dependent segment of the population. They may then be caught in potentially contradictory expectations; to integrate effectively to increase their organization's power in the larger system; and to develop a structure and system which reflects the nature of their community, a social system different in many ways from the dominant society. Integration is a goal which clearly identifies a product outcome - to be like those dominant. Accommodation leads towards the unknown, the to-be-determined, and is more difficult to define.

Members of the acting community can come to enjoy the fruits of dominance and this too may encourage a focus upon integration and maintenance of the status quo.

The majority of northern Saskatchewan residents are marginal to collective decision-making in the planned change process. A community development or empowerment approach would stress the involvement of these marginal people in the decision-making process. Yet they can obviously not be forced to participate. DNS must support the acting community. It could also encourage them to find ways to expand their numbers and include more people.

The situation is rife with complexities and possible contradictions. These contradictions may or may not be experienced by the participants in the process as dilemmas. In the following chapters the focus of the discussion will narrow to one specific area, namely health, and one program and emergent role, that of Community Health Worker, in this dynamic northern Saskatchewan context.

CHAPTER V

HEALTH AND DEVELOPMENT DILEMMAS

The title of the Community Health Worker program indicates the broad social processes with which it is concerned, community and health. The association of the two concepts in the title reflects the perception that community and health are indeed linked. This is consistent with considering health in the context of planned development and seems to suggest a universalistic approach. However, the goals and some of the dynamics of the change process in northern Saskatchewan which we have discussed lead us to investigate the degree to which contradictions manifest themselves in attitudes and responses to health and health care.

The Problem of Poor Health

Health and health care can be considered a basic need and a basic right. Medical technology has progressed so rapidly that medical miracles have become commonplace. Yet many people, particularly poor people, suffer ill health continuously.

Kai Erikson (1976) writes perceptively of the way in which health is a symbol for people, a representation of their more general state of being.

> "Health has something to do with feeling whole and being in harmony with the larger physical and social environment." (234) "In a sense, illness or infirmity comes to serve as a recognizable name for the otherwise vague maladies

> that plague people..." (112) "People who view the world as out of whack and themselves as broken, fragmented, and torn loose from their moorings often use illness as a way to signal themselves and others what the nature of their discomfort is." (112) "Illness is one of the options open to people who need to define themselves by their disabilities because they no longer respect or derive a measure of selfhood from their abilities." (228)

Erikson sees health as a measure of a person's integration of self and environment and their degree of satisfaction with that. People in northern Saskatchewan do not enjoy the same standard of health as those in the southern part of the province.

This problem is recognized by the provincial government and the northern people.

Health problems in their communities were defined by the LCA's as:

- the dog problem;
- the garbage problem;
- everything;
- a hospital or better hospital;
- resident doctor;
- birth control - less control by the Church;
- resident nurses.

The Ile-a-la-Crosse LCA indicated to me in May 1979 that health care was being looked after by the experts so they were content to leave well enough alone.

The health problems most often identified by the nurses were:

- infections, especially respiratory and ear;
- alcohol abuse;
- lack of adequate nutrition;
- improved cleanliness and tuberculosis.

Other needs or problems stated by the nurses were:

- venereal disease;
- family planning;
- accidents and violence;
- family breakdown;
- proper clothing in the cold season;
- lack of dental hygiene;
- pre- and post-natal education;
- a permanent physician;
- knowing what's normal vs. abnormal;
- people coping for themselves;
- information on child care.

Community Health Workers' responses regarding health problems were:

- dogs;
- teenage pregnancies;
- liquor;
- birth control;
- too much junk food;
- a good store with cheaper food, particularly vegetables and milk;
- babies with diarrhea and colds;
- pre-natal nutrition and new houses with running water. (It was mentioned that people with running water do not have lice.)

The Native Health Association, a seemingly shortlived group in Buffalo Narrows in 1974, identified the following causes and area of concentration for a proposal for a health education project: (The order presented is theirs.)

Problem Areas in Northern Saskatchewan

- alcohol;
- medical prescriptions (barbiturates and tranquillizers) dependence due to lack of proper medical and health facilities and personnel;
- cigarettes;
- nutrition.

Consequences:

- juvenile delinquency;
- social problems (broken homes, unwed mothers, family fights, etc.);
- criminal acts;
- child abuse;
- health problems (highest birthrate, highest death rate, lower life expectance, greater number of illness separations (SHSP), more prone to respiratory and lung diseases).

Causes:

- inadequate health and medical facilities and personnel (great quantities of drugs given out to relieve various symptoms as there are no adequate treatment centers;
- lack of alcohol and drug counselling;
- virtual non-existence of recreational facilities;
- communication gap between natives and government program;
- lack of economic development and subsequent dependency on welfare;
- virtual absence of news and information media (what is available is difficult to relate to);
- danger of drug abuse not realized.

Others of concentration:

- venereal disease (is it a problem in the North? are people aware of symptoms, and where to get treatment?);
- Hashish, Marijuana, L.S.D., M.D.A., etc. (are drugs getting to the north?);
- Indian medicine, herbs and roots for treatment of illness (are Indian medicines still being used in the remote areas?);
- birth control (how accessible is birth control to the women and men in the north?).

Obviously there is no shortage of examples of the health problems in northern Saskatchewan. Much energy is being expended trying to solve them. People in northern Saskatchewan are being torn loose from their moorings and are seeking a new equilibrium. Alcohol abuse is widespread, and often referred to by northerners as 'drinking', not as 'being drunk'! The choice of words connotes a process or activity not a state, and I think correctly reflects their view.

People in northern Saskatchewan seem unsettled. Their concern with health, and particularly treatment services, reflect this state of flux. Demand for treatment services remains high and requests for expanded service are frequent. There seems to be a corresponding lack of demand for health educative or preventive services. Disease, not health, is the priority.

There is a mystique regarding medical and health services which is reflected in the comments of the people. The health worker in Beauval mentioned many times that people there preferred to see the 'real'doctors in Meadow Lake rather than the physicians on contract with DNS in Ile-a-la-Crosse. Meadow Lake is farther from Beauval but the physicians in Ile-a-la-Crosse are young and there is constant turnover.

In communities which used to be served by outpost hospitals (Buffalo Narrows, Cumberland House, Sandy Bay, and Stony Rapids) until the early 1970's, the health centre is still referred to as the 'hospital.'

A 1978 planning study for Buffalo Narrows referred throughout the text to the 'outpost hospital.' The consultants' lack of clarity about the distinction between 'health' and 'medical' services is demonstrated by their interchangeable usage of words, i.e., they ask respondents to rate medical services and then document that "Sixty-two per cent (62%) of the people surveyed rated health services as poor." (Amisk Planning Consultants, 1978, 47, emphasis mine). Their text reveals other inaccuracies, e.g. a statement that the community health worker had quit before completing training.

While noting the distortion in their research, the findings are still of interest. "The most frequently suggested improvements were a resident doctor, a new or larger hospital and better qualified and more experienced nurses."* Treatment is most often identified as the health need.

Demand on existing treatment services is high. Unfortunately, data on treatment services provided to northern residents are not collected and organized such that exact figures are retrievable. We know how many treatment contacts the nurses or health workers have (approximately 20,000 in 1978-79) but not how many different people they see. We know how many hospital admissions are recorded in the four hospitals in the Northern Administrative District, but not how many N.A.D. residents seek hospitalization, physician services, dental care, etc. outside the N.A.D.**

It is clear that there are many health problems in northern Saskatchewan. Whose problems are they however; what is their root and how might they be solved?

A reasoned problem definition lays the base for productive, creative problem solving. In the social sciences, this nurtures the 'sociological imagination' discussed by Mills (1959). The way in which the problem is defined is critical. Too often problem solvers rush into action without clearly defining the problem, or checking

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* See Appendix C for more details from this study

** It must be noted that many of the disease problems, especially communicable diseases, gastro-intestinal and respiratory infections have been largely due to environmental factors. With improved housing, and sewer and water services, these disease rates are dropping. In the last six years hospital admissions in Ile-a-la-Crosse and La Loche are down 36%; in La Ronge, 5%; in Uranium City, 6%.

the assumptions inherent in their problem definition. The definition given to the problem determines the direction for action. It implies a paradigm which includes having an understanding of who has the problem, identifying ways in which the definition can be approached, and making a choice of definition. It is important to clarify assumptions.

A recent cover of New Internationalist (see Appendix D) forcefully illustrates the assumptions in problem definition. Population control without distribution of resource control merely perpetuates dependence and a problem!

Ryan's (1976) distinction between exceptionalism and universalism is one useful approach in analyzing the way problems in health are defined. Exceptionalism or victim-blaming focuses on providing services to clients or consumers, whereas universalism coincides with changing the social structures, including power relationships, a process often related with community development activity.

The 'Blaming the Victim' ideology as with any ideology, subtly directs people's attention to a specific problem definition in a complex problem situation.

The poor health and inadequate health care of the poor is often explained away on the grounds that the poor have poor motivation, lack health information, delay in seeking care when they experience symptoms, and seek care for minor problems they could handle themselves. "There is little doubt that persons who are members of the lowest socio-economic groups find it difficult to understand and appreciate the value of preventive services." (Yerby, 1965, 1212-16).

Reid, Arnaudo & White (1968, 2) summarize the opinions and findings of writers who hold what the authors call the "psychological point of view":

> "The low income person frequently lacks knowledge of, or information about, physiology, medical etiology, good health practices, and the work of the health-care practitioner. He often lacks ability to use information intelligently or to follow the practitioner's advice. And he is more likely than persons at other income levels to have inaccurate information concerning health and treatment of disorders, to be more fearful of ill health and of using health resources, to be more uncomfortable in health-care facilities, and to be more distrustful of practitioners."

The perspective adopted in these statements is essentially identical to Ryan's victim-blaming. The syndrome is pervasive, particularly in the health care system.

The nurses in northern Saskatchewan with whom I spoke frequently identified community members' attitudes towards health and health care as:

- they've a long way to go;
- no preventive action, e.g. wearing a hat;
- they want a hospital;
- they want pills;
- no understanding of prevention;
- they want symptomatic relief;
- they don't think they can do anything by themselves;
- health is not a priority;
- they want what they think they should have, e.g. a doctor for a sore throat;
- some people don't feel they are responsible;
- people generally are quick to seek help for health problems, even minor ones;
- some people are becoming more aware because of continuous teaching;
- people are developing some sensitivity to expectations, e.g. have A535 in the house.

These perceptions exemplify the exceptionalistic approach. Reflected in the nurses' comments is the belief that there is a problem with people's attitudes towards health and health care and that the problem is with the community residents, not the system or the services. This attitude precludes the possibility that the deliverers of health and medical services might consider changing their attitudes or their system. The attitude also places responsibility on the individual without recognizing that personal power in and control of the health care system is essential. One cannot be responsible for something over which one does not exercise control.

The community health workers had less to say on the topic of their perceptions of community members' attitudes towards health and health care. They made comments such as:

- people aren't against it, some maybe;
- they won't take pills;
- old people prefer home remedies but usually won't tell what's in them, if their way doesn't work they'll eventually come around, most of them;
- they only think about health when they're sick, they won't go for an x-ray if they feel good;
- they've never had anything like this before;
- hard to say, people are different.

While less articulate than the nurses the comments of the CHW's indicate that they are less inculcated with and less committed to the exceptionalistic ideology. They are less sure of how to define the problem.

DNS Health Services staff are, for the most part, diligent and dedicated. They work hard to do their jobs as best they can. They have mostly been trained with an exceptionalistic medical model

(i.e. fix the victim) and that is how they define the problem facing them at work. Their perspective is reinforced by their perceptions of community needs. Obviously valid exceptionalistic services are needed, and will continue to be needed. But when that is all that is offered the problem will not be solved. Ryan (1976, 19) notes:

> "The danger in the exceptionalistic viewpoint is in its impact on social policy when it becomes the dominant component in social analysis. Blaming the Victim occurs exclusively within an exceptionalistic framework, and it consists of applying exceptionalistic explanations to universalistic problems."

It is easy to fall into that trap when considering health and health care.

The La Loche Social Impact Study (Schacter, 1976) also identified the need for resident medical professionals in that community. However, that analysis probes more deeply into the situation experienced by community residents and points out that health cannot be considered in isolation. Food costs are very high in northern Saskatchewan* and are a limiting factor in nutritional status, particularly for people living on fixed and/or minimal incomes. Schacter is sensitive to the relationship between social factors, self-image and health. "The poverty of people, coupled with the apathy and frustration which arise from the lack of gainful employment, create a mix of conditions." (18) He mentions malnutrition,

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* An appalling irony is that liquor is subsidized and thus the same price everywhere in the province while food is not. A recent DNS program is subsidizing food transportation costs to the far north but affects only five communities.

pneumonia, bronchitis, infections, scabies, intestinal problems; and hypertension, duodenal ulcers and heart failures in younger people. The latter group particularly are "indications of greater strain which arises under conditions of high unemployment and dependency." (18) Schacter is defining the problem broadly and universalistically.*

And so it needs to be, I think. George Smith, Overseer of the LCA in Pinehouse, in a report to the Electors on August 27, 1979, talked about Mayoayawin, Cree meaning good health. "It is a state of being among people and their community." In the same address he notes that "there are some aspects to good health besides clinics, doctors, and nurses. Mayoayawin also means housing, jobs, opportunities for our youth, and many other things to help us grow and live."

Smith has articulated the universalistic approach. He has also identified the cornerstone for development. "Who is better than ourselves to look after the health care of us all?" He could have added - and through looking after things ourselves we will enjoy better health.

Health Care Approaches in 'Developing' Countries

Poor health is certainly not experienced only by northern Saskatchewan residents. It is one of the major problems associated with poverty and anomie world wide.

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* Another observation of Schacter's is that the Church should get out of the health care delivery system. The Catholic Health Council operates the hospitals in Ile-a-la-Crosse and La Loche. This causes real problems for the people who want birth control information or devices and for unwed mothers. A discussion of that problem is beyond the scope of this paper.

Many people working in health care in 'developing' countries have come to the conclusion that the perceived problem of poor health cannot be effectively tackled through foreign experts offering cures. Carroll Behrhorst, in Health by the People, about the Chimaltenango Development Project in Guatemala, concluded:

> "Health has many facets-economic, political and social. Each must be taken into account when the epidemiology of any human health problem is being considered. Proper care for any ailment, physical or social, demands dedication to the treatment of causes, not merely the amelioration of current pain." (1975, 52)

His description of his realization that health must be defined and then approached holistically includes a marvellous metaphor:

> "Curing the ailing...was something like trying to empty the Atlantic Ocean with a teaspoon. It made the toiler feel active and useful and caused everyone to exclaim: "My, what a beautiful teaspoon!" " (Behrhorst, 1975, 31)

Newell (1975), in his conclusion to Health by the People, summarizes the emphases placed by the ten authors writing about the health care projects in their countries. Most of the authors had identified the importance of wider issues on health including:

- productivity and sufficient resources to enable people to eat and be educated;
- a sense of community responsibility and involvement;
- a functioning community organization;
- self-sufficiency in all important matters and a reliance on outside resources only for emergencies;
- an understanding of the uniqueness of each community coupled with the individual and group pride and dignity associated with it'
- the feeling that people have of true unity between their land, their work, and their household.

These issues definitely point to the relationship between community and health, as noted by Erikson, and support the value of universalistic as well as exceptionalistic approaches.

Conclusion

There is no doubt that health in northern Saskatchewan is a problem. For long term northern residents the problem is identified as poor health and inadequate services. Health staff often feel overwhelmed, frustrated and unrecognized. They have a firm grasp of the teaspoon but it seems to have a perpetual leak.

Newell, in the Introduction to Health by the People, states:

> "It is difficult to work out the reasons why members of the health services have tried to separate 'health concerns' from other parts of the complex. Is it because we do not understand the problem or feel incompetent or powerless to influence the main issues, or because we want to 'control' our own field?" (1975, x)

People structure reality according to the labels with which they learn to organize it. It is to be expected that highly trained health professionals will define and attack a problem using a frame of reference that they understand, particularly when they perceive the community members to need and want the services they have been trained to provide.

It is evident that the contradictions previously identified in planned change situations are present as well in the more specific context of health and health care. If health is perceived to be a

reflection of people's general sense of well-being, of their sense of integration of self and environment, then the solution to health problems could be sought through a community development approach. A goal of health care workers in northern Saskatchewan could be to help northern people gain control over all aspects of their lives, including health care, and by so doing witness an improvement in people's health status.

However, a poorly organized community (which might appear to need community development activity) will probably not be organized enough to request or push for it. Demand for treatment or crisis intervention services will likely be high, yet providing only that service is likely to perpetuate the need for it.

Health care personnel are for the most part trained to perceive health problems in an exceptionalistic framework - that is the essence of the medical model. (An exception to this is some public health professionals - e.g. Medical Health Officer, Public Health Inspectors.) Within the exceptionalistic approach there is still a distinction between treatment or medical services and preventive or health services.

Health and health care can be considered basic needs and basic rights. Health does not appear to be a priority for northern residents, however. People seem to think health only when they seek medical aid and then they think treatment. This poses a dilemma for health care workers who believe in the importance of good health and see it as a prerequisite for fulfillment in other life activities.

Should they push health issues and information at community members and local government or respond only to requests? Should they provide only what is asked for, i.e. mostly treatment services, or do they try to promote health awareness? When they choose the latter course, are they being helpful or 'blaming the victim'?

Most health care workers, due to their training, orientation and desire to respond to identified wants, will likely retain the exceptionalistic approach. In fact, increase in utilization rates may appear to justify this.

> "It is easy to say that food is what is needed by a malnourished child and that community development is a mechanism that can be used to supply it. It is hard to say that community development is a goal and that communities in the process of developing find a way of seeing that children get food." (Newell, 1975, 192)

The reported perceptions of people in northern Saskatchewan of what the health problems are, what their root is, and who should solve them demonstrate lack of agreement and contradictions. It can be anticipated that these may cause difficulties for a role occupant, particularly in a role a t the interface.

CHAPTER VI

THE COMMUNITY HEALTH WORKER PROGRAM

Having outlined the context within which the Community Health Worker program and role have been developed, the program and role will now be examined.

Health Services Branch

On April 1, 1973, the Health Services Branch was formed. It assumed responsibility for delivery of both routine and special programs operated by the Department of Health. Operating expenses of the larger hospitals and payment of fee-for-services physicians remained covered by the Saskatchewan Hospital Services Plan and Medical Care Insurance Commission.

> "...with responsibility for Health Services vested in the department which is exclusively devoted to the North, it has been increasingly possible to adapt and develop programs which aim at meeting the problems and needs particular to this region." (1974-75 Annual Report, Department of Northern Saskatchewan, 44)

Health Services Branch has six main program areas (see organizational chart, Appendix E). At the time of this research they are:

1) Medical: Three contract physicians based in Ile-a-la-Crosse serve the west side of the northern region. Four private physician clinics (La Ronge, Uranium City, Flin Flon and Nipawin) receive financial assistance for travel to outlying communities.

2) Nursing: Twenty nurses provide both primary diagnosis and treatment as well as public health and mental health services.

3) Public Health Inspection: Four Public Health Inspectors interpret and enforce relevant legislative regulations as well as offer consultant and educative services to local councils and the public.

4) Dental Care: The DNS Dental Plan provides diagnostic treatment and preventive services to children to age sixteen.

5) Administrative and Clerical: This program provides support services to all staff.

6) Health Education: Four Health Educators and ten Community Health Workers provide educational materials, medical presentations, workshops, face-to-face teaching on health-related topics and community organization around health issues.

The Community Health Worker Program

The Community Health Worker program in northern Saskatchewan is deceptively easy to describe briefly. Community Health Workers are native northerners working as local health promoters in their home communities.

The program encompasses a variety of people; community health workers, nurses, council members, health educators, community members who receive service from the workers, and other human service workers with whom Community Health Workers connect (e.g., physicians, social workers, teachers, health inspectors). The health workers, nurses,

local councils and health educators interact within a contracted (although loosely defined) relationship. This contract (see Appendix F) provides structures designed to achieve certain development goals.

The main actors in the program are the health workers. There are presently funds for ten health workers in ten communities (soon to expand to fourteen). They are northern natives, long-time residents of the community in which they work, who receive training and then work as local health educators/promotors/liaisons. Presently all the health workers are women. They are employed through a three-way contractual agreement between the health worker, the local council or Northern Municipal Council (NMC) and DNS. Local councils are nominal employers. At the time of the research most health workers are based in the local health centre with professional supervision provided by the nurse serving the community. Training, co-ordination, program administration and overall direction are provided by the health educators.

Community Health Workers are not government employees, rather they are local council employees. Direct employment costs such as salaries, employer and employee contributions to mandatory insurance/benefit schemes, etc. are paid through DNS Health Services to local councils. Support service costs (office space, equipment, and materials; travel and sustenance; consultants and education materials) are paid directly by Health Services. The program is cost-shared federally by the Department of Regional Economic Expansion (DREE) through the Northlands Agreement, by which sixty percent of monies expended are reimbursed to general provincial coffers.*

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* The DREE support does not directly affect Branch or Department reaction to or support of the program. However, it is probably a factor which facilitates receiving the approval of the Provincial Treasury Board to allocate funds to the program.

The Community Health Worker Program Goals

The Community Health Worker program goals and policies can be seen as incremental in terms of the overall DNS goals. The health worker program is an attempt in one specific area, namely health, to reach department goals. It can at the same time be viewed as a separate program, with fundamental and incremental policies of its own.

Documented Community Health Worker program goals and policies were explored in the course of this research, e.g., budget submissions, Treasury Board approval, letters to DNS management and staff, letters to communities, and the like. Different words are used but the meanings are consistent with the following excerpt from a brief written by the then Acting Director of Health Services for the then Deputy Minister of the DNS in February 1975 about the Community Health Worker Program:

> "This programme provides for local para-professionals working at the grass-roots level to instill health awareness and thus promote individual and community action toward lasting improvements in the general level of health among northerners. It is based on:
>
> i) recognition that it would likely be impossible to recruit professional medical staff in sufficient numbers to cope with the vast scale of health problems.
>
> ii) realization that the effectiveness of the professional 'outsider' is limited.
>
> iii) the 'self-help philosophy for community development: improvements are most effectively brought about through determination and participation by the people themselves." (Thomson, 1975)

These principles provide the program with a philosophical framework that contains a potential contradiction. If (as is suggested in (i) above) it is desirable wherever possible to recruit professionals, then the self-help and community involvement ideals are weakened.

Schedule A of the Community Health Worker contract (Appendix F) is a statement of duties and objectives. The duties outlined fall into four main categories:

a) public education through home visits, teaching in schools and to adult groups, etc.;

b) liaising between the health service system and the public by translating and interpreting and assisting in delivery of public health programming;

c) providing emergency first aid and appropriate referrals in the absence of a health staff person;

d) acting as a catalyst for community development through locality development, social action or shared social planning.

Local councils, as employers, are thus provided with a mechanism to become more aware of health issues and to take action with community members to improve conditions affecting health.

Program Procedures

In 1974-75 (April 1 - March 31, the fiscal year) funds were allocated to Health Services to contract with local councils for five community health workers. The immediate problem was to determine which five of the many northern communities would become part of the program. In 1977-78 funds for five more workers were released. The program is requesting money for five more in 1980-81.

The rationale and procedure initially developed for selection has been implemented, with a few revisions, over time. Notification and request for input were sent to all local councils, the Northern Municipal

Council, Association for Metis and Non-Status Indians, Department of Northern Saskatchewan, Assistant Deputy Ministers and branch heads. Criteria developed were: request from community council, community population size, health services in community, and jurisdiction (federal or provincial or both).

There is no question the DNS Health Services management made the final decision regarding community selection. Input received from various sources has been instrumental in decisions to date, however.

In time of expansion communities with no Community Health Worker were generally given priority over larger communities already receiving services from a health worker. Initially, communities with a resident DNS nurse were selected.* Experience with similar programs managed by the federal government had indicated the importance of on-site health support and supervision staff. As the program has grown, more consideration has been given to communities with no other health personnel.

Once communities have been selected, the people to be trained as health workers are chosen.

The local council manages the competition. Notices are placed around the community advertising the position. Application forms are submitted to the local councils. An ad hoc committee made up of local council member(s), a nurse and a health educator makes a recommendation for selection to the local council. Criteria for selection as outlined in the DNS Health Services guidelines given to local councils are:

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* The exception is Beauval, a community with no health service staff. That worker is still in that role. This situation offers an interesting study for a health status comparison, with and without a nurse.

- ability to speak both English and the native language of the community (Cree or Chipweyan);
- neat appearance (i.e., model cleanliness and good health habits);
- maturity;
- literacy (no definite grade is required, however);
- ability to meet and speak easily with community people, preferably a long-term resident of the community;
- willingness to leave the community for training sessions.

During the interview self-confidence, initiative, and the history of the applicant's involvement in community groups and activities are assessed.

Until recently health workers received training with health workers trained by National Health and Welfare for Indian reserves. The training period lasted six months and included four three-week classroom sessions interspersed with practicum periods in their community. The workers received training in self-awareness, communications, public speaking, problem solving, counselling, community development, basic health information, first aid, home nursing, use of audio-visual aids and teaching skills. Beginning in 1980 nine new workers will be trained by DNS, not National Health and Welfare.

It sounds like a good plan. If the goals were attained northerners would be individually and collectively informed about and responsible for their own health. Knowledge, attitude and behavior changes in northern residents, as well as employment and integration of northerners in health service delivery would occur.

The Community Health Worker Role

The Community Health Worker program in northern Saskatchewan is an attempt on the one hand to increase availability, accessibility and

utilization of health services and on the other hand to promote community organization, development, and control. The contradictions inherent in these two goals are reflected in the program structure and in the difficulties encountered by the Community Health Workers.

Many factors influence role behavior including personality characteristics, structural constraints, norms, sanctions, and ignorance. Among the important influences on role behavior are the role occupants' perceptions and expectations for herself and the impact of her perceptions of the expectations of significant others particularly those in the role-set. The role of Community Health Worker is emergent, and the occupants are mainly responsible for the creation of its day-to-day reality.

The people identified in the CHW contract as linked with the Community Health Worker, e.g., the nurses and the local councils, will be considered important parts of the CHW's role-set. Their expectations of CHW role behavior have influence on the CHW. The CHW spends a large proportion of her time with community residents and therefore her perceptions of their expectations of her are also important.

The discussion of the context of the program and role would suggest that the Community Health Worker is in a position to be easily affected by the contradictions inherent in the different situations for which her role is the interface. She may well feel pulled and pushed and may react with withdrawal, confusion or ambivalence.

The Nurse

Since the nurse is a primary member of the CHW's role set, let us first examine some of the nurses' perceptions and expectations for

the Community Health Worker role and program.

Nurses' expectations of the community health workers were stated as:

- teaching health classes in school,
- making home visits to pre- and post-natals and the aged to teach and/or provide home treatment occasionally and make referrals,
- she knows what's going on in town,
- she can assist the nurse to obtain health histories,
- interpreting,
- assist with special clinics, i.e., optometric and audiology,
- teach T.B. patients about their drugs,
- she's showing more independence, e.g., organizing for baby clinic,
- well, she's not a nurse you know,
- to teach about birth control,
- she's important as a buffer for the nurse - she can tell the nurse or the patient the other's needs or reasons for actions,
- she has become part of the medical services, it's hard to believe we coped without her,
- the Community Health Worker is in a closing vice between the people and the institution,
- I'd like to see her go into the community more and explain the nurses' stance,
- she can treat scrapes,
- she needs to be more independent.

These statements emphasize the perceived value of the CHW as a liaison with community people and as an assistant to the nurse in public health programming. None of these comments make explicit reference to a community development function. From my observations of and conversations with the nurses I know that they are aware of that function but are not themselves trained for or comfortable with it. The nurses stated that they thought the program goals were:

- to promote a better understanding of health and prevention of disease among the Indian population through individual teaching and home visiting,
- to provide co-ordination with other helping people,
- to encourage native people to pursue careers in the health field,
- to promote some type of preventive care,
- long term re-education of people,
- to promote better (responsible) attitudes toward health - people need to know that they can be healthy,
- to provide a liaison between the community and the nurse,

- to provide the community with a local person who can relate better and do health education,
- to help with acceptance of public health - public health is new.

These comments indicate an awareness of goals more general than those reflected in the statements about their expectations of CHW role behavior.

The nurses stated that they expected program results to be:

- health workers will reach their own people, they are better able to understand and assess the needs of the natives,
- local people will be encouraged to participate in planning and carrying out health programs,
- assist people to reach and maintain standards of health and living conditions comparable to those enjoyed by the Canadian white population,
- it will take ten years to really see results - health workers need time to adapt the methods and messages - thus overcoming the cultural and communication gap,
- more people are coming to the clinic on their own for immunization,
- unclear, maybe a health committee will result,
- no immediate results are expected, it's a slow process of attitude change,
- increased rapport and acceptance of health services - make the community more aware of what we try to do,
- improved immunization status.

Program results are expected to promote both exceptionalism and universalism, and both integration and accommodation, although the expected role behavior reinforces only integration and exceptionalism. The nurses did not express as many ideas of what they expect from themselves with respect to the health worker with whom they work. They stated that they expected to be a resource person for her, spend lots of time with her, help her become independent, and provide supervisory guidance.

There seems to be agreement among the nurses that the health workers contribute greatly to the effectiveness of programs and services.

They bring insight, community and language knowledge, and energy to the team effort.

The Local Councils

Let us now look at the reaction of the local councils to the Community Health Worker and CHW program. There has been limited structured interaction between the NMC, LCA or LAC and the worker, and only vague models for how that interaction might be increased. Until recently, health has not been articulated as a priority for local government in the north. Councils seemed content to pay the health worker and not pay much more attention to her role. They did not respond to requests to explore ways of increasing their involvement in the program. In the past six months there has been an exciting increase in expressed desire for involvement with and control over the worker. It is difficult to determine the precipitant factors in this change. It may be reflective of an increasing trend of northerners demanding control over their own affairs.*

Councils with whom I spoke about the program mostly expressed lack of knowledge and confusion about their part in the program. Their statements included:

- we pay her or something, don't we?
- we have so many other things to do, we don't know much about health,
- things seem to be going well - we don't want to mess when things are good,
- the bookkeeping is an administrative hassle,
- it's a way for the community to have a local health person.

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* The Bayda Inquiry and controversy over involvement in mining activity is an issue around which control issues are solidifying. Councils are also developing a history which is probably increasing their confidence.

When asked about what they thought the health worker did, they responded:

- she works with government,
- we don't know,
- she works with senior citizens,
- she helps the nurse,
- she's the nurse's assistant,
- she's a local contact person for the people,
- she teaches birth control,
- she's a community development worker,
- she interprets,
- does she give needles?

Councils always expressed support for the program, but until recently were content to see themselves as mostly the administrative vehicle for its implementation. That is changing. Pinehouse, Sandy Bay, La Loche, Ile-a-la-Crosse and Michel Village have had a Community Health Worker for at least two years. Now these councils are expressing desire to have more involvement and control. They are considering structural changes. An example is the suggestion that the health worker be located in the LCA office. They are exercising more control over hiring and discipline. Weyakwin, Jans Bay, Turnor Lake and Cole Bay councils are taking concerted action to have a health worker trained for their community.

Northern people, in and out of DNS, are becoming more organized. With this organization is coming demand for more control over their own communities. That is one of the goals of DNS, yet this very process is a source of concern to many DNS staff.

In 1974-75 a group in Buffalo Narrows developed a plan for a health education project run by them. In 1979 the LCA in Pinehouse decided to try to form a health board to run activities at the health centre. In 1979 the LCA in La Loche requested that the health worker have her office at the LCA rather than the health centre.

Plans for the Native Health Education project were good and demonstrated initiative and concern. But DNS Health Services had just submitted their proposal for creation of the health education program (1 Health Educator, 5 Community Health Workers) to Treasury Board. It was approved; the government kept control.

The Pinehouse plan drew the immediate reaction that the LCA had better not think they would control the nurse. Control and direction of the health worker was also questioned. They would get no collegial support or supervision and how would the council know what to do with them?

The La Loche plan caused the resident nurses there great concern. How would the LCA know what to do with a health worker? Wouldn't services be diminished?

The above examples demonstrate the resistance to change which seems to be a common reaction to suggestions of different methods. This resistance is lessened somewhat when the change is understood as a reclarification or redefinition of goals. The La Loche nurses' opposition diminished when the potential of the proposed move was explored with them.

I informed the DNS nurses at a conference in May 1979 that I had asked the health workers to set up meetings for me with their LCA/LAC. I hoped to explore the level of involvement with the worker desired by the council and seek mechanisms to attain it. I met considerable resistance. The nurses expressed concern that conflict and diminished service to them and the community by the health worker would result. These are possible outcomes.

A few of the nurses, some of whom had experienced a positive outcome from a similar unsettling process, pointed out that this process was perhaps the only way for program and community development, and that what was lost in immediate service delivery might well be made up for in long term gain.

I think they are right. The DNS and the Community Health Worker program are working toward goals which may not be internally congruent. They require different focuses.

Self Perceptions

How do Community Health Workers perceive their role? The following are their statements about what they expect from themselves (the first six were often repeated):

- to get people to understand about health, e.g. why wear a hat?
- to talk in Cree & Chipewyan & English - to interpret,
- I work with the nurse,
- I make home visits,
- it's hard to explain,
- I should do more community activities,
- to help community people,
- I should spend more time with community people, I'm in the clinics too much,
- to be trustworthy,
- to teach expectant mothers to care for themselves, e.g., nutrition and exercise,
- people depend on me more than the nurse because they're more open with me,
- I'm too shy - but it's a hard town to get involved with - people fight among themselves,
- I talk to people about V.D. who won't talk to the nurse,
- I do too much clerical work,
- I need to be more of a leader - speak out more,
- I feel caught in the middle sometimes,
- people have never had an Indian nurse or doctor, so I explain things to them,
- I visit the elderly,
- I feel real good working because I know I'm working with people,
- I expect myself to help out, e.g., take people their drugs in winter,

- to do alcohol awareness with youth,
- to check eyes, ear & throat at the school,
- to organize things for the optometrist and audiologist.

The Community Healty Workers expect themselves both to assist with delivery of public health programming and to provide leadership in community organization and information about health concerns. Furthermore, since the nurse is a central figure in the health worker's role set, the nurse's expectations of the health worker as perceived by the health worker are significant in helping her to define her role. CHW's stated that they think the nurses expect them to:

- do a good job,
- visit the people, especially the elderly,
- help around the health centre,
- teach classes to children in school and adults,
- let her know what I'm doing,
- explain the people in the community to her,
- give people messages.

The health workers, in return, expect the nurse to help them define and do their job.

Similarly the Community Health Worker's perceptions of community members' expectations of her may influence her expectations of herself. They may also reveal the way in which she views herself within the community context. CHW's stated (the first three statements were often mentioned):

- they expect confidentiality,
- they know that they can call me at home,
- I'm someone to talk Cree to - especially the old people,
- they expect teaching,
- elderly expect lots of visits - their face lights up when they see me,
- to fix a cut finger,
- to give them birth control information,
- I'm not sure,
- to run weight-watchers,
- that I'm half nurse, half teacher,

- that I have influence with the nurse,
- sometimes people think I should know more - they get mad when I don't know,
- they've never had anything like me before,
- they expect me to drive them all over,
- they want an explanation of why I'm there when I'm on a home visit,
- people are pretty satisfied,
- they say 'here comes the nurse'.

The Community Health Workers perceive the community members as expecting treatment, teaching and provision of a liaison/interpreter function.

At this point it is interesting to compare the nurses' expressed perceptions of the community expectations of the CHW:

- it's hard to know because native people are very reserved in the expression of their feelings,
- I don't get much feedback, I'm not sure,
- I think they're slightly suspicious, they wonder if she's a snoop,
- they expect her to do her job, they don't really know what that is,
- she's getting more and more phone calls, they must expect something from her,
- to give out pills,
- they expect her to be a taxi,
- for a very few the Community Health Workers give the image of being health educators,
- it's hard to judge, so much goes on under the surface,
- they expect her to be a mini-nurse.

It is clear that while the nurses perceive community members to be unsure of the exact role of the CHW, they <u>are</u> aware that there are expectations for her to provide some medical or nurse-like services. The CHW herself is also aware of these expectations to be a "mini-nurse" and they may help to contribute to her role dilemma.

For the most part the Community Health Workers are not sure what the results of their work will be. They say things like "It's hard to know but people's attitudes are changing - people are trusting

and talking" and "behaviors take a while to change."

Role Behaviour

An investigation of what the Community Health Workers have actually been doing in their respective communities reveals that the pattern of their activities varies only slightly from traditional public health programming. They work mostly one-to-one with people in the health centres or assist the nurse with clinics (e.g., child health, immunization, doctors' days, etc.), make 'home visits' to follow up patients or convey messages from the health centre, work with the nurse conducting in-school screening sessions (e.g., vision, hearing), conduct classes in schools or with adults (e.g., fitness), and respond to medical emergencies with first aid and/or appropriate referral.

In 1978-79, Community Health Workers reported approximately 3700 home visits. About half were considered to be educative rather than treatment focused visits. They made approximately half of those visits on their own. In the same year they reported seeing approximately 1200 people in the health centres; one quarter of those without a nurse or doctor present; and of that quarter, one half of the contacts were considered educative. They saw approximately 1600 people in the schools, acting independently of the nurse about two-thirds of the time. Most reported acting independently more often as they gained confidence and competence.

Community Health Workers have also played a part in community organization activities. They have worked with day care boards, native women's groups, recreation boards, and local school boards. In most

cases these organizations are newly formed. Their members are learning both the process of political group action and creating the structures within which the action can happen.

These activities which could be viewed as central to the health workers' role are often perceived by the workers to be outside of it. The role-set influences the role occupants' perceptions of legitimized role behavior.

On the job Community Health Workers have most of their contact with the nurse and with the public. Those relationships probably have the most impact on the role-set of the CHW, and as stated earlier, the nurse is likely to be the most significant role model.

The fact that the CHW is employed by the council is likely to be known only to her, to the health staff and to the council. Community members see her in the health centre, or with health staff. They have little reason to perceive her as anything different from a government employee and often refer to her as 'the nurse.' They expect her to provide treatment, and ask her questions that she cannot always answer. She gets answers from the nurse.

The LCA's, at the time of this study, provided little direction to the Community Health Worker. A visiting health educator, reflecting the health education goals for the program, encourages her to do more community organization and education. Visiting public health inspectors, mental health nurses and on occasion dental staff will enlist her help in their activities. Her relationship with the LCA is mostly administrative; with the health educator(s) and other health staff, intermittent and consultative; with the nurse, regular and central.

Conclusions

The Community Health Workers are providing a valuable service and are perceived to be important members of the health care team. Their role is emergent and unfamiliar to health services staff and to the communities. The structure of the program is complicated and somewhat contradictory to the process. Different actors in the role-set of the CHW have internally contradictory and inconsistent expectations of her role behavior and possible results of her work.

Some specific contradictions have been discussed. The philosophy and goals of the program promote both professionally dominated exceptionalism and community development oriented universalism. During training and on a continuing intermittent basis health educators and other health staff, including nurses, express support for the community development philosophy. The structure of the program, with LCA and LAC's as employers, seems also to support an empowerment approach. Yet the CHW's are physically located in the health centres thereby maximizing their involvement with health staff and minimizing their contact with the LCA or community members. Most of the contact CHW's have with community members occurs when those residents are receiving service from the health care system, thereby reinforcing an exceptionalist model. With little structured contact and a belief by many council members that health is best looked after by experts (a belief which perpetuates the mystique of professionalism and dependency) the LCA's and LAC's remain only nominal employers.

The Community Health Worker's role is deliberately loosely defined (there are guidelines in the contract but no job descriptions)

in order to allow for community specific needs and role identification. In the absence of any other clear direction the nurse becomes the role model for the health worker. This is reinforced by the perception that people in the community define the Community Health Worker in a nursing framework. The health worker forms an idea of what public health programming is by internalizing the definition operationalized by the nurse. However, health professionals repeatedly remind her that she is not a nurse.

With this understanding, it ceases to be surprising that the health workers often measure their skills and knowledge against the nurses' and feel inadequate. We can appreciate more readily why the health workers often do not take more initiative either around the health centre or in the community. The Community Health Workers feel dependent yet they are expected to model independence; they perceive themselves to be part of the health care system, yet actually occupy a hazy position outside of it.

The interface worker is faced with a related and perplexing dilemma. Wharf (1979) refers to it as:

> "the necessity of gaining legitimation and at the same time preserving a capacity for introducing, or at least being supportive of, innovations. The danger is that in the process of earning the right to propose changes one may become so comfortable with the accepted procedures that the capacity to think in unconventional terms is lost or severely impaired." (17)

Warren et al (1974) call this "institutionalized thought structure" (87) and document many examples of it. I observed situations in which CHW's became distressed with the thought that they might have to move their office at the LCA/LAC's request and possibly have to

change their work activities to fulfill a more community-based role.

The contradictions in the context, the program and the role seem to invite what Merton & Barber (1963) term sociological ambivalence in which ambivalence comes to be built into the structure of social statuses and roles, into their social definition. People in these roles experience confusion and mixed feelings. Health workers in northern Saskatchewan are expected, and perceived themselves to be expected, to be both nurse's assistant and community development workers. They are smack up against a classic community work dilemma.

CHAPTER VII

CONCLUSIONS

> "The most important advice I can give the contemporary sociologist has nothing to do with the validity of my arguments. It is this: you do not have to believe anything about theory and methodology that is told you pretentiously and sanctimoniously by other sociologists - including myself. So much guff has gotten mixed with the truth that, if you cannot tell which is which, you had better reject it all. It will only get in your way. No one will go wrong theoretically who remains in close touch with and seeks to understand a body of concrete phenomena." (Homans, 1964, 951-977)

The above quotation has been a reference point in this research. There is an overwhelming amount of relevant literature in the discipline, and many approaches which could have been chosen. In this case the process has been one of immersion in the social world being studied, complemented by extensive appraisal of the literature. It is the emergent understanding of the social reality which has guided the determination of appropriate approaches. The aim has been to understand the significant factors in the role-set and other contextual aspects of the Community Health Worker program which contribute to confusion and ambivalence and possibly dilemmas for the CHW role occupant, a community worker operating at the interface of dominant and dependent segments of a population.

The Department of Northern Saskatchewan, in all its programs and, specifically, in the Community Health Worker program, is attempting

to realize two distinct goals which suggest the need for different approaches and structures, and may, in fact, be in conflict with each other. DNS is not unique in this respect. The literature review revealed that a common problem in planned change processes is the attempt to promote both integration and accommodation and both exceptionalism and universalism, through a single complex intervention.

One goal of DNS is to modernize northern Saskatchewan by providing services and structures so that the people in the region can attain a standard of living comparable to the rest of the province. They would then, as a region, be able to integrate effectively into the provincial power and support system.

The other goal is to facilitate and promote development in people and communities such that they become powerful, and self-regulating. They can then shake the dependency syndrome which can be immobilizing to those who experience its impact.

It seems realistic to accept both goals as valid. While the pure community development approach would focus only on the latter goal, it must be recognized that northern Saskatchewan does not exist in a vacuum and must be considered in the context of the province and the country. Southern Saskatchewan is not going to go away. In one sense, this gives the people in the north what they want; in the other, it removes their option of independently determining what they want. The extent to which standards and services in the north are comparable to those in the south precludes putting integration on hold. Northern people have come to expect and desire the services which the dominant group in southern Canada enjoy.

If both goals are accepted then the issue becomes a recognition that contradictions will pervade the context and role of a community worker like a CHW unless it is very clear which goal is being attempted through which processes. Identification of the contradictions and dilemmas does not remove the structural influences on role ambivalence but it is the first step to trying to minimize contradictory expectations in the role-set. If the distinctions between the goals are clarified, structures and fundamental and incremental decisions can be more congruent.

In northern Saskatchewan there are enough physicians and nurses to provide minimal treatment services. Obviously, they will expect, and be expected, to do so. In those countries, e.g. Guatemala, Tanzania, India, where very different health care structures have developed they have been sanctioned largely because there were not enough highly trained professionals to provide the service. It is widely recognized in those countries that physicians are not needed to provide basic health care because experience has proven that local people with basic training perform the job well. The relatively few physicians in the aforementioned countries apply their expertise in cases of intensive treatment need. The arrangement is practical there. It will not be accepted here, nor with the availability of highly trained treatment sources should it be.*

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* The issue of whether our society should support the expensive training of these and other professionals is a separate one.

Erasmus (1968) notes that much community development activity is often misguided because developers, infused with a co-operative ideal, promote action which is contrary to the reality of the social situation for the people. They try to encourage systems appropriate for 'mechanical' (Durkheim, 1933) society when the people perceive their need to be to compete in an 'organic' one. There is nothing inherently immoral about 'organic' society. The determining factor should be the degree of autonomy experienced by its members.

Accepting that some integration is desired by the people in northern Saskatchewan and is inevitable does not negate the importance of pursuing accommodation consciously. It is my belief that when a dependent group has experienced its own separate history and culture it is unfortunate if, in the search for personal and collective power and control, the separateness is completely lost. Therefore, accommodation can probably be given some priority, since integration will happen anyway. It is important to keep the product and the process separate, to know which goal is pre-eminent in a given situation, and then to take appropriate action to attain it. As Fairweather says, "the means for creating social change should be compatible with the goals of that change." (1972, 3) That becomes difficult when the goals become confused with one another.

It is evident that confusion and uncertainty are experienced by the participants in the Community Health Worker program. I submit that this is due, in part, to a lack of clarity of goals and thus a confusion about appropriate means and structures.

There is conflict in any process where power and control are the issues. It is imperative to minimize the conflict inherent in the goals. Energy can then be expended where it is needed - in the process of working towards solution of the problem.

Examining the social context has led to the specification of fundamental contradictions in the program and its goals with which community workers are faced. Identification and clarification of these contradictions can help us to understand the confusion and ambivalence in the community health worker role, as well as to move forward in more coherent program development.

CHAPTER VIII

IMPLICATIONS

"Why does one engage in doing something that in reality never comes, and never can come, to an end?" (Weber, 1946, 45) Research does not provide us with 'the answer,' and even if it did the question could change at any time.

Research does give us information - a valuable asset. A question asked by a classic sociologist is still vital: "Why strive for knowledge of reality if this knowledge cannot serve us in life?" (Durkheim, 1933).

Of what use is the information gained through this research? Goulet states that politics should not be "the art of the possible" but "the art of redefining the possible." (1971, 336) That sentiment can also be applied to planning in development situations.

The information and insights about the Community Health Worker role can be used to clarify other development processes as well as to imagine possible directions for the program itself.

The health service delivery system is likely to become more firmly entrenched in northern Saskatchewan. The structures may take on a number of different forms. DNS is programmed to disband. At that time the Department of Health may recreate a northern region and administrate basically the same system. It may happen, as some LCA's like Pinehouse are suggesting, that local health boards will be formed to hire the health staff and manage the health centres. Co-ordination

would be required and that could be done through a northern health association or the Northern Municipal Council.

It does seem reasonable to expect that physicians and nurses will continue to provide the bulk of the service. Hopefully, those roles will be increasingly performed by native northerners.

What will happen to the Community Health Workers? The health worker role as idealized by program planners and participants may become anachronistic.

There is no career ladder within the health services system for people without professional training. As the people in northern Saskatchewan become more 'sophisticated' (i.e., speak English, understand the health services more completely) the need for a liaison may diminish.

I see four possible scenarios for the future. (There may be others).

Maintenance - Things could stay the way they are. This means continuing confusion but it is not without redeeming features. Good work is being done by the health workers. They are reaching some of the people, providing them with health information, and easing the integration into the system. The program is providing a mechanism for employing northerners in the health care system - a challenge in a professionally dominated field.

To ignore the dilemmas is to leave the program needlessly suspended in ambiguity and the Community Health Workers in limbo, however. They cannot enjoy the satisfaction of living up to program ideals because they are limited by structural factors such as their physical placement and the role-set thus created.

They cannot provide more than emergency treatment, and treatment is what people want. Treatment contacts are an organic situation in which to offer information because people are experiencing a problem or need at that time. Their educative role could be enhanced by structuring an interview between the health worker and the patient in the health centre after a treatment contact. In this meeting the health worker could check out the patient's understanding of the problem, how to remedy it, and how to prevent a recurrence. Community Health Workers would probably still feel inadequate, thinking that the nurse had more information; and patients might resent the structure.

In this scenario the complicated administrative structure would remain only a mechanism for channelling funds; health workers would still have limited input. The workers, however, would be seen more consistently as educators.

Integration - The health workers' role could be formalized as outreach or liaison officers and nurse's assistants. They could become government employees and be incorporated fully into the health services system. Role confusion would be eliminated. Administration would be simplified. Training could be focussed more directly on their assistant functions. Expectations would likely be more closely aligned with behaviour.

Possibilities for innovative responsive programming would be greatly diminished. Community Health Workers would be identified formally as the least powerful people in the service structure. Structured contact with the local councils would be lost. There would still

be no career ladder for the health workers. It would be very difficult, if not impossible, to get money or positions for the changed role. The community development/control rationale would be lost.

Accommodation 1. - The local councils would become the only supervisor - preferably through creation of a health or community service board or committee, comprised of local council members, community members and a health staff, reporting to the local council. The worker would have her office at the local council office, or other community building.

The health worker role could be more clearly defined as working with local people and groups to identify health problems, interests and concerns, relating these interests and problems to local council or health committee and health centre staff, being or arranging for resource people to meet with interested community individuals or groups, challenging existing and lobbying for desired services, and/or whatever the health committee identified.

The health worker could still help health centre staff follow up patients or organize programming, but the nurse or other staff would have to request these services - in effect contract for them. There could still be a trainer/consultant for the workers and councils or committees provided by Health Services, Northern Municipal Council, or other central agency.

The health worker role would then be defined in terms of community needs and she would be more likely to be perceived as a community worker. The reference group and role models for the health

worker would be the councils and other community workers, e.g. native women, day-care workers, community development workers. She would not compare herself with, or be seen as, a nurse. Her perception of what is possible might not be as structured within traditional public health programming.

The health workers would have a different possible career path with local government or community organizations and would not be affected as directly by whatever happens to the health service structure in the future.

Training for the workers could focus more upon community development and organizing skills, e.g. communication, problem solving, counselling, conflict resolution, organizing, leadership, running meetings, government structures and resources, as well as basic health concepts and first aid. Training could be co-ordinated with that for other community workers - with special modules for the workers' speciality, e.g. health, day-care, or recreation, etc.*

There are some problems. Health services staff would lose their built-in interpreters, assistants, and team members. Community Health Workers would lose their present co-workers and health staff models. They would probably need assistance in defining their role.

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* The lack of effective education and training available in the north for all northern community workers, councils, boards and staff, is a concern to me and an area in which I would like to become involved.

Health committees would need to be supported. As noted earlier, councils presently have their hands full.

The advantages seem to outweigh the disadvantages. This structure would turn one of the present dilemmas into a positive. Because there are professional resources provided through integration of southern and northern systems, the workers could take a more active role in the community development without threatening basic health care services.

Accommodation 2. - Community development workers could be employed by local councils or local boards in each community. These workers could focus exclusively on the process of locality development or social action. As noted previously, activity which promotes citizen power and control would be likely to promote improved health. Community development workers would be of tremendous assistance to community members and to community workers such as health workers.

If these workers were to replace health workers, however, care would have to be taken to avoid having them be swamped with requests from community residents and professional workers, such as health and social services staff, for liaison functions. There still seems to be a need for the interface role at this point in time.

Community development workers and community health workers could form an effective team, particularly if the health workers were working in the structure suggested in alternative Accommodation 1.

Maybe we can maximize the best and minimize the worst of both worlds in northern Saskatchewan. It is definitely worth a try.

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APPENDICES

APPENDIX A: INTERVIEW GUIDE

What are the health needs in your community?

What are community health/health care attitudes? How are they demonstrated?

Is the Community Health Worker program meeting any of the health needs? Which ones? If not, why not?

What do you think the goals of the program are?

What do you expect will happen as a result of the program in the short and long term?

If anything were possible what would the results of _____ work in this community be?

Realistically, what do you think is likely to happen as a result of her work?

What do you think community members expect of the C.H.W.? Are they feeling satisfied?

What do you think _____ does with her work time? What kind of activities? How do you feel about that? Where do you think she should spend her time. Is she involved in enough community activities?

What do you expect from yourself with regards to this program?

Are you meeting your expectations? If not, why not?

Are you aware of any community expectations of you for this program? What are they?

How would you feel if the program were stopped?

Do you think it is important that the C.H.W. be from the community?

Do you think the structure of the program (three party agreement, DNS supervision and co-ordination) is adequate? Can you think of a better structure?

Do you read her month end reports? What do you get out of them? Are you satisfied with the present recording/reporting system?

Are there any changes you would like to see in the program?

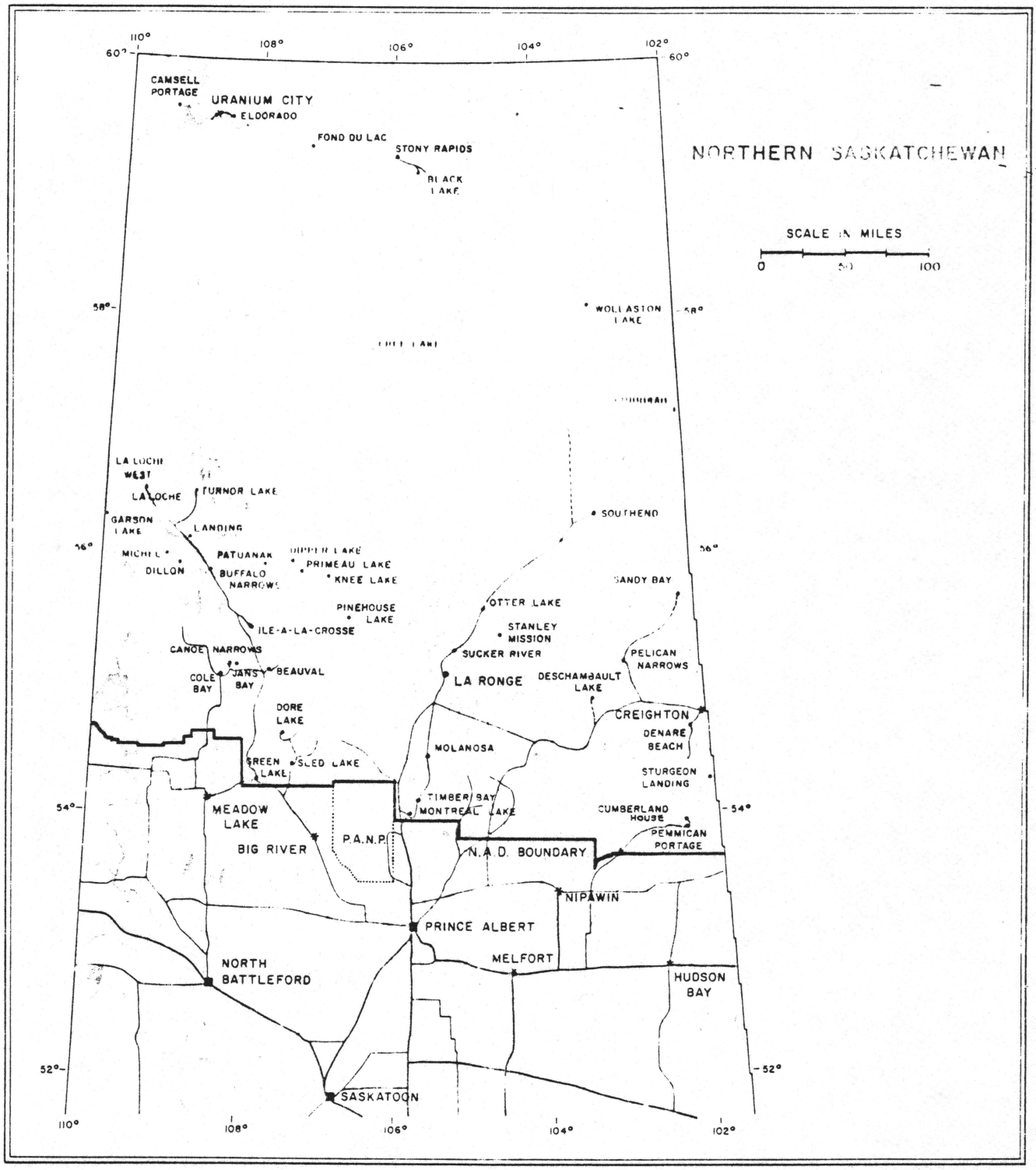
How do you think we can tell if the program is successful?

Who do you think I should talk to to get a good idea of how the program is developing?

How much input has the C.H.W. in the LCA or LAC? Is she involved in the months meetings? If not, why not?

Have you any other comments?

APPENDIX B: MAP OF NORTHERN SASKATCHEWAN



APPENDIX C: THE BUFFALO NARROWS PLANNING STUDY - EXCERPTS

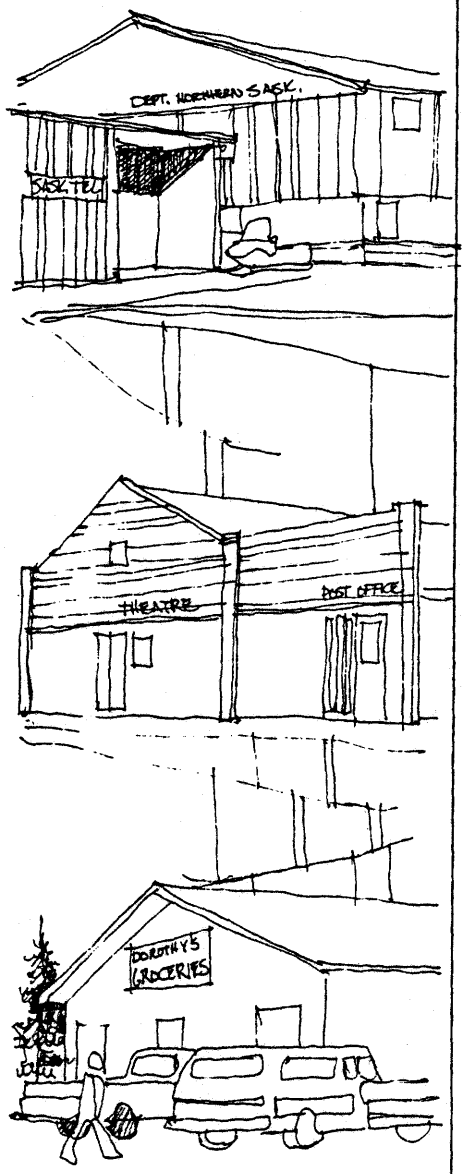
INTRODUCTION

Buffalo Narrows is situated on the west side of a large area presently administered by the Department of Northern Saskatchewan. Northern Saskatchewan comprises approximately 40 percent of the total land area of the province and has less than 3 percent of the province's total population. The majority (two-thirds) of the people in the North are of Indian ancestry and support themselves in low income industries through wage employment, lumbering, commercial fishing, trapping, or welfare. Most live in the more than thirty small communities sprinkled throughout the North and generally lack education and industrial job skills. Traditional bush skills of hunting and trapping are gradually disappearing in the young people. While people of non-Indian ancestry comprise less than one-third of the Northern population, they generally have more education, training and experience; consequently, they occupy the majority of management positions in industry, business and government.

Over the last thirty years, populations of Indian and Metis people in Northern Saskatchewan have increased dramatically, mainly due to lowered death rates (a result of improvements in village health care, housing and other facilities and services). This increasing population generally has not been matched with a corresponding expansion of the economic base and employment opportunities; thus many northern communities are faced with problems of over-population and underemployment.

Encouraged by medical and educational services, together with housing and employment opportunities, the native people of Northern Saskatchewan have gradually forsaken a migratory hunting and trapping existence and come to reside year-round in permanent settlements. This has resulted in profound changes in their economic and social patterns. As population growth has increased ahead of employment opportunities, successive governments, both provincial and federal, have become ever more involved with northern communities in providing not only increasing amounts of social assistance but also various programs aimed at increasing employment and encouraging economic and social development.

Source - Seaborne, A. A., 1973. "The Population Geography of Northern Saskatchewan", Periodical, The Musk Ox No. 12



EMPLOYMENT BY SECTOR

Table One

Government Sector	No.	Commercial Sector
A. DNS		
Resources	9	Athabaska Airways
Radio Communication	3	Buffalo Narrows Aviation
Northern Continuing Education	1	Buffalo Helicopters
Economic Development	4	C & M Airways
Social Services	17	Archie's Taxi
Sawmill	19	Forest Theatre
Northern Housing	21	McKay's Taxi
Maintenance & Operations	11	Helen's Cafe & Pool Hall
R.R.A.P. Program	2	Hudson's Bay Company
Outpost Hospital	12	Jessie's Cafe
N.M.C.	3	Len's Excavating
Outreach	3	Imperial Oil Ltd.
Local Community Authority	7	Serights Esso
Twin Lakes School	21	Pedersen's Service
Total	133	Waite Fisheries Ltd.
		Kelly's Plumbing & Heating
B. Province		Dorothy's Store
Ferry	4	Alex's Bookkeeping Service
North Sask. Electric	2	K. C. Warehouse & Bottle Exchange
Sask. Tel.	2	Vicki's Motel & Cafe
Liquor Store	1	Buffalo Narrows Hotel
Total	9	Clarke's Bus Lines
		Total
C. Federal		
R.C.M.P.	12	
Weather Station	3	
Indian Health	3	
Total	18	

Sources: -Outreach Buffalo Narrows
-Authors

EMPLOYMENT SUMMARY

Table Two

Sector	Number	Percentage
Government	(1) 160	51%
Commercial	(1)(2) 88	28%
Fishing	(3) 45	14%
Trapping	(4) 20	7%
TOTAL	313	100%

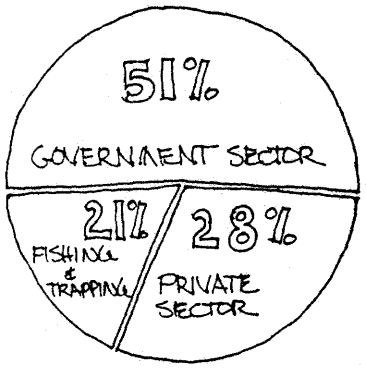
Sources 1) Outreach, Buffalo Narrows Office
2) Author
3) Outreach
4) G. Bonneau, Conservation Office
Buffalo Narrows

Table Three

Category	No.	% Of Employables	% Total Population
Total Employables Age 15 to 64	589 (1)	100%	56%
Employed	313	53%	30%
Unemployed	276	47%	26%
Actively Seeking Employment	35 (2)	6%	4%

Sources: 1) SHSP, June 1977 Population Figures
2) Outreach, Buffalo Narrows
June, 1977

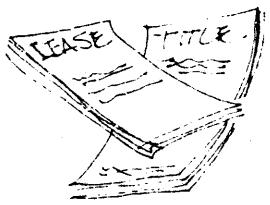
EMPLOYMENT CHARACTERISTICS



The government sector provides the majority of jobs (51%) with the private sector providing 28%. The traditional pursuits of fishing and trapping combine to provide 21% of the jobs. Over half (53%) of the persons considered employable are employed and Outreach indicates that another 6% are unemployed and actively seeking work. Unlike more southern communities where 45% of the population is often in the labour force, 30% of Buffalo Narrows residents are employed.

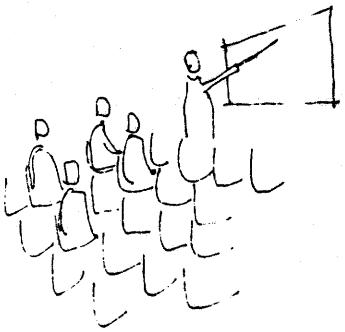
The resident survey conducted by the consultant in February compared favourably with the figures in Table 3 with 59% of those surveyed being employed.

LAND OWNERSHIP

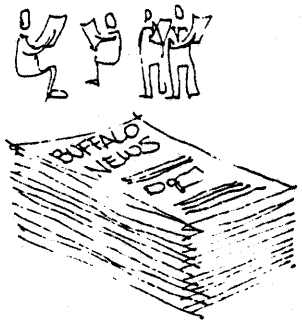


There is confusion about the land ownership situation in Buffalo Narrows as explained in Appendix 2. The major problem is with leases. Only one lease is on file and yet many parcels of L.C.A. owned land are occupied and taxes. People occupying L.C.A. owned land without a lease are squatters and have few legal rights. Copies of four leases available from D.N.S. files indicate unrealistically low lease rates. Efforts should be made to remedy the situation by clarifying and recording lease information.

COMMUNICATION



In Buffalo Narrows community, communication is a problem. People are poorly informed and learn of most local news via word of mouth, at best an imprecise means of information distribution which leads to distortion and confusion over issues and which makes cooperative community action difficult. Communication is poor between the L.C.A. and the community. Eighty percent of the residents surveyed did not know what happens at an L.C.A. meeting, while ninety-three percent would like to know and wanted more information about what is planned for the future. In spite of this, there is poor attendance at most public meetings. Communication is also poor between the various government agencies and the community; little discussion takes place between local D.N.S. officials and the L.C.A. and important decisions are often made by each side without consulting the other. The intentions of government programs are often not clearly defined or explained to the recipients nor is enough time allowed for community residents to study and evaluate programs before their implementation. There is need for regular meetings between the L.C.A. and government officials.



From the resident survey it is evident that people are not well aware of local elected officials such as L.C.A. members, Northern Municipal Councillor, or Northern School Board Member. Better communications would increase the community knowledge of these people and the work they do. While most (seventy-nine percent) of the people surveyed said the L.C.A. makes most of the decisions, people indicated that they felt they should help to make decisions. Overall people are poorly informed about local affairs and expressed a desire to be better informed and a desire to be part of the decision-making process. The apparent apathy on the part of community residents may be more a result of limited information and few opportunities to become involved. There is need for an information program to explain and to discuss L.C.A. and D.N.S. objectives and programs.

HEALTH CARE FACILITIES

Three nurses live in Buffalo Narrows and work at the Health Centre half time and also make home visits and follow-up on cases. Two of the nurses travel to other communities 2 days a week. All three take turns being on call. A doctor comes 3 days a week from Ile-a-La-Crosse to see patients at the Health Centre. A woman had been training as a community health worker but quit before the end of the 7-month training period. A Community Health Worker would supplement the nurses in the community. There is a 12-bed hospital in La Loche and a 36-bed hospital in Ile-a-La-Crosse The Health Centre in Buffalo Narrows has 2 examining rooms, 3 offices, one medication/treatment room and one drug supply room.

In the resident survey, 62% of the people surveyed rated health services in Buffalo Narrows as poor. The most frequently suggested improvements were a resident doctor, a new or larger hospital, and better qualified and more experienced nurses. People feel that Health Centre hours should be longer and that more staff should be on duty after hours. People indicated a strong dissatifaction with existing medical services and the people directly involved with deliverying those services.

RECREATION FACILITIES AND ACTIVITIES

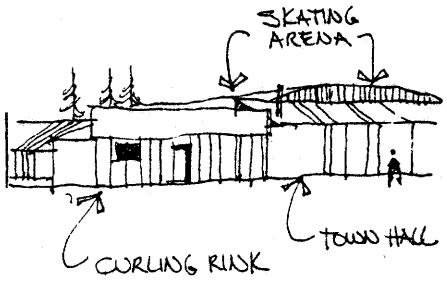
The recreation board is responsible to the L.C.A. During the winter of 1977-78, one recreation board resigned and after some time a new board was formed. A series of recreation directors have been hired and another was in the process of being hired.

Recreation Board

Buffalo Narrows has a variety of recreation facilities available for public use. A list and description follows.

Existing Facilities

1. curling rink - 2 sheets with viewing room
   - general condition poor
2. skating arena - uninsulated steel structure with wooden bleachers on one side
   - ice size smaller than regulation hockey ice
   - general condition poor
3. town hall - joining curling and skating into one complex
   - all three share washrooms and concession stand
   - used primarily for bingos
   - general condition poor
4. ball diamond - one for entire community, backstop, fence and bleachers on lakeshore
   - general condition fair



Decision-making

People were asked to name certain elected representatives for their area. (Chart 13) An average of thirty-seven per cent (37%) of the people surveyed know each of the seven L.C.A. councillors, and thirty-seven per cent (37%) do not know any of the councillors. Eighty per cent (80%) know that Fred Thompson is the M.L.A. for Buffalo Narrows. Fifty-five per cent (55%) know that Bruce Clarke is the Northern School Board member for Buffalo Narrows. Fifty-eight per cent (58%) know that Frank Petit is the Northern Municipal Councillor for Buffalo Narrows. Except for the M.L.A. people are not well aware of their elected representatives.

Chart 13

ELECTED REPRESENTATIVES RESPONSES

L.C.A. Councillors	No.	Per Cent	Member of the Legislative Assembly	No.	Per Cent
Philip Chartier	38	37.2	Fred Thompson	68	79.1
Thomas Chartier	34	39.5	No Answer	17	19.8
Ken Petit	33	38.4	Incorrect Answer	1	1.1
Thorvald Peterson	33	38.4			
David Seright	32	37.2	Northern School Board		
Norm Tinker	28	32.6			
Sigfried Reigert	17	19.9	Bruce Clarke	47	54.7
No Answer	32	37.2	No Answer	32	37.2
Incorrect Answer	31	36.0	Incorrect Answer	7	8.1

Northern Municipal Councillor	No.	Per Cent
Frank Petit	50	58.2
No answer	31	36.0
Incorrect Answer	5	5.8

Most (79%) of the people said that the L.C.A. makes most of the decisions about Buffalo Narrows and some (19%) believe that D.N.S. makes most of those decisions. Most people (81%) felt they had no influence on decisions made about Buffalo Narrows. Just over two-thirds of the people (68%) thought all the people should make decisions and another third (33%) thought the L.C.A. should be responsible. Very few people feel that either D.N.S. or the N.M.C. should make most of the decisions about Buffalo Narrows. (Chart 14, 15, and 16)

Chart 14

WHO MAKES MOST OF THE DECISIONS ABOUT BUFFALO NARROWS?

Group	No.	Per Cent
L.C.A.	68	79.1
N.M.C.	4	4.7
D.N.S.	16	18.6
No response	1	1.2

Note: Some people chose more than one answer.

Chart 15

DO YOU THINK YOU HAVE ANY INFLUENCE ON DECISIONS MADE ABOUT BUFFALO NARROWS?

Response	No.	Per Cent
Yes	10	11.6
No	70	81.4
No response	6	7.0

Chart 16

WHO DO YOU THINK SHOULD MAKE MOST OF THE DECISIONS ABOUT BUFFALO NARROWS?

Group	No.	Per Cent
L.C.A.	29	33.7
N.M.C.	4	4.7
D.N.S.	1	1.1
All of the people	59	68.6

Note: -Some people chose more than one answer.
-Percentages are of the number of people surveyed.

Seventy-nine per cent (79%) of the people surveyed do not know what goes on at an L.C.A. meeting but most (94%) would like to know. People said that they (93%) want information about what is planned for Buffalo Narrows in the future so that they know what is going on, and because their family's future is in Buffalo Narrows. Several people suggested that if they knew what was planned they could help or get involved and perhaps have some input.

Chart 17

A. DO YOU KNOW WHAT HAPPENS AT L.C.A. MEETINGS?

Response	No.	Per Cent
Yes	14	16.3
No	68	79.1
Sometimes	3	3.4
No response	1	1.1

B. WOULD YOU LIKE MORE INFORMATION ABOUT WHAT IS PLANNED FOR BUFFALO NARROWS IN THE FUTURE?

Response	No.	Per Cent
Yes	80	93.0
No	4	4.7
No response	2	2.3

Health Services

Thirty-three per cent (33%) of the people surveyed rated health services in Buffalo Narrows as fair, and sixty-two per cent (62%) rated health services as poor. The most frequently suggested improvements were a resident doctor, a new or larger hospital, and better qualified and more experienced nurses. People feel that Health Center hours should be longer than they presently are and that more staff should be on duty after hours. Some people requested air ambulance service. Responses to this question indicate that people are dissatisfied with the existing medical services and the people directly involved with delivering those services.

Chart 19

RATE MEDICAL SERVICES IN BUFFALO NARROWS

Rating	No.	Per Cent
Good	4	4.6
Fair	28	32.6
Poor	53	61.6

Chart 20

WHAT COULD BE IMPROVED OR WHAT IS NEEDED?

Responses	No.
New hospital	17
Hospital	6
Larger hospital	3
More modern facilities	1
Resident doctor	41
Doctor	12
Better/good doctor	8
Doctor's office	2
Not to see a new doctor every week, we aren't guinea pigs	1
Better qualified/experienced nurses	14
Nurses not part time/ there at all times	2
Nurses not just for emergencies	2
Good nurses	2
More concerned nurses	1
R. N. staff	1
Smart nurses	1
Nurses	1
New nurses	1
Found a nurse on duty at a party	1
Dentist	8
Air ambulance	5
Doctor and nurses there when needed	4
Doctor and nurses there from 9 to 6	3
Hospital not restricted to certain hours	2
Want 24-hour service	2
Fewer coffee breaks	1
Too much waiting	1
If medical care needed, then give it	1
Ambulance for emergencies	1
Hospital only open after 1:15, have to wait if a a child is sick	1

Results of Resident Survey

Background

In February Amisk Planning Consultants hired six local people to take a questionnaire to Buffalo Narrows residents whose names had been selected at random from the 1976 L.C.A. voters list. Altogether ninty-five (95) people were surveyed. This article is a summary of the results. This summary and conclusions drawn from it will be included in the final report to be produced at the end of the planning study.

General Information

Almost all of the people surveyed speak English and half of them also speak Cree. Half of the people surveyed have lived in Buffalo Narrows all of their lives and another twenty per cent (20%) have lived in Buffalo Narrows over half of their lives. About thirty per cent (30%) of the people surveyed have lived in Buffalo Narrows for the last few years only.

People were asked what they liked and did not like about Buffalo Narrows. People like living in a small, quiet town where they are close to their relatives and where they know everyone. They value living close to lakes and the bush where they can easily go fishing and camping.

People were most criticial of the bar and of drinking. Children hanging around outside the bar is seen as a problem. The lack of recreation activities and facilities is the next biggest problem. People want more recreation organized, especially for children so that they have something to do. Also mentioned were too many stray dogs, poor streets, garbage thrown around town and lack of shopping, banking and medical facilities.

Employment

Most (59%) of the people surveyed are presently employed. No calculation of unemployment was undertaken in this survey since Outreach has that information. Half of the employed work at office jobs and the rest are employed at various jobs throughout the community.

Half of the people surveyed want more job training for themselves. Most of this training requires technical or vocational school training and some involves university courses. The most frequently requested training was in the secretarial, clerical, bookkeeping and accounting area. Some people want training in the broad area of social work to get jobs in rehabilitation, probation and community services. Others want to be a heavy equipment operator, carpenter, electrician, cook, nurses aide, dental aide or a teacher. A few other jobs of similar variety were also mentioned but there are too many to list here.

Recreation

Present recreation activities in Buffalo Narrows are not highly rated mostly because there are too few activities for all age groups, especially for children and old people. It is felt that the Recreation Board could improve recreation in several ways. It needs to work harder as a unit for better recreation for the whole community. More recreation facilities for activities other than curling and hockey or skating are needed and existing facilities need improvement or replacement. It was suggested that the recreation board should get people interested and involved in supporting recreation within their community. Parents could work with children as volunteers or coaches. There is also a great need for more organized activities and for a recreation director with training.

People were asked what recreation facilities were needed in Buffalo Narrows. Their answers in order of most frequent response are:

1) bigger or new indoor arena
2) park-playground and a beach facility
3) gym for public use with equipment
4) drop-in centre for teenagers
5) new or improved curling rink
6) recreation complex (no activities identified)
7) community hall and club rooms for old people

Shopping

Half of the people surveyed travel from Buffalo Narrows to another centre once a month mostly for shopping and medical services but also for banking, business, car service and hair care. A few go to another centre twice a month and most of the rest go only a few times a year. Very few people do not leave Buffalo Narrows on a regular basis. People go to Meadow Lake more often than other centres but they also go to Prince Albert, North Battleford and Saskatoon.

People were asked to estimate how much of their shopping they did outside of Buffalo Narrows. Forty per cent (40%) of the people buy all or most of their groceries, fifty per cent (50%) buy all or most of their clothing, twenty-five per cent (25%) buy all or most of their furniture, forty-four per cent (44%) buy all or most of their hardware outside of Buffalo Narrows. This represents a sizeable cash flow out of Buffalo Narrows.

Decision Making

People were asked to name the Local Community Authority (L.C.A.) councillors who are: Philip Chartier, Thomas Chartier, Thorvald (Skipper) Pederson, Ken Petit, Sigfried Reigert, David Seright (overseer) and Norm Tinker. Thirty-seven per cent (37%) of the people surveyed did not know any of the councillors. An average of thirty six per cent (36%) knew each of the councillors. Eighty per cent (80%) knew that Fred Thompson is the M.L.A. for Buffalo narrows. Fifty-five per cent (55%) knew that Bruce Clarke is the Northern School Board member for Buffalo Narrows. Fifty-eight per cent (58%) knew that Frank Petit is the Northern Municipal Councillor for Buffalo Narrows. Altogether except for the M.L.A., people are not well aware of their local representatives.

Most (79%) of the people said that the L.C.A. makes most of the decisions about Buffalo Narrows and some (19%) said that D.N.S. makes most of the decisions. Most (81%) people felt they had no influence on the decisions that are made. While many (68%) felt that all the people should make decisions about Buffalo Narrows, some (33%) felt that the L.C.A. should make these decisions.

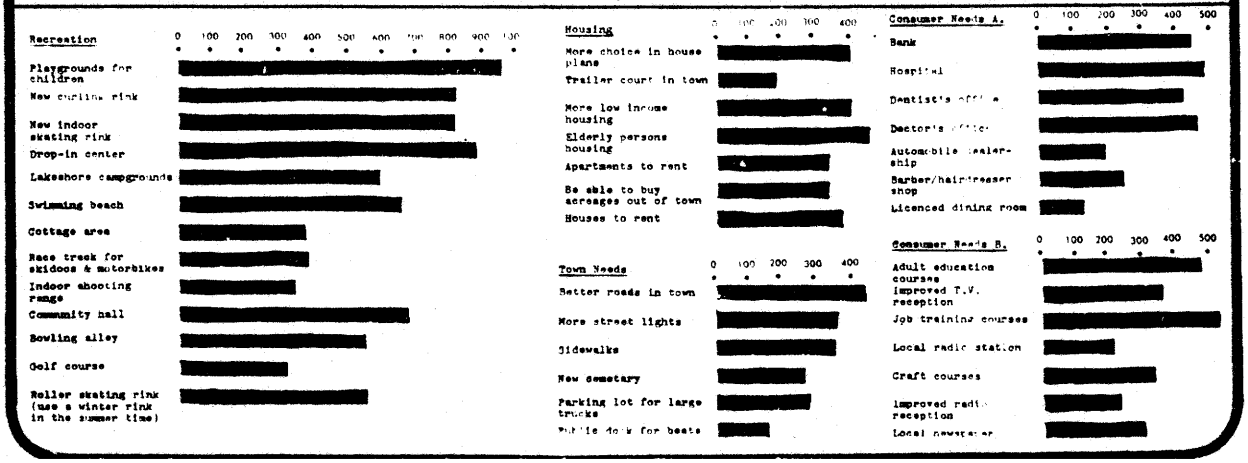
Seventy-nine per cent (79%) of the people surveyed do not know what goes on at an L.C.A. meeting but most would like to know mainly because they want to know what is going on in their community.

Medical Services

Nearly everyone (95%) rated medical services as poor or fair. Suggestions to improve the service vary. Many want longer office hours with a doctor and nurse on staff, a resident doctor and an active hospital, either new or improved. Some of the people want air ambulance service. Many people suggest that the nursing staff should be better qualified and more experienced. Responses to these questions indicate discontent with existing medical services and the people directly involved in delivering that service.

Community Needs

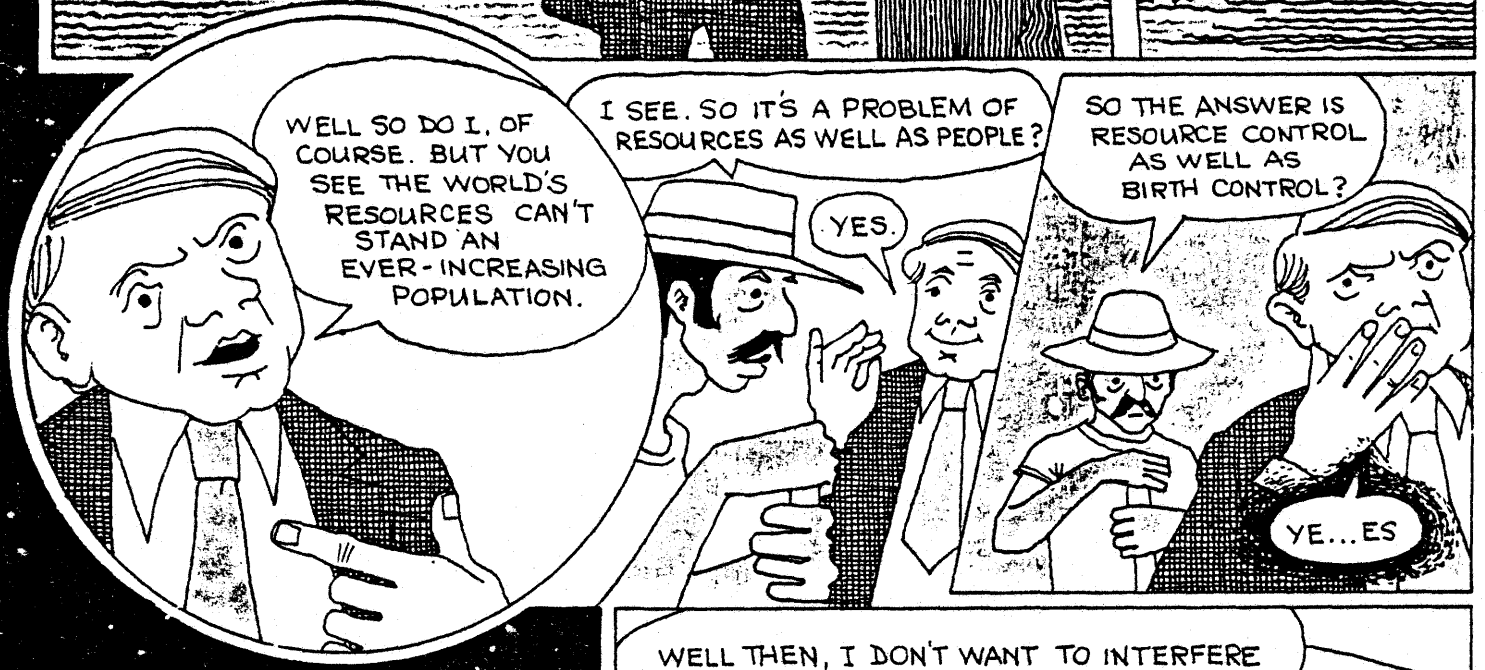
This last question asked people to rate different groups of choices. The five groups of choices are shown in the following graphs. The numbers at the top of each graph represent points and the length of each bar is determined by the number of points earned by each choice. The longer the bar the higher the rating for that choice.



International

THE PEOPLE THE IDEAS THE ACTION IN THE FIGHT FOR WORLD DEVELOPMENT

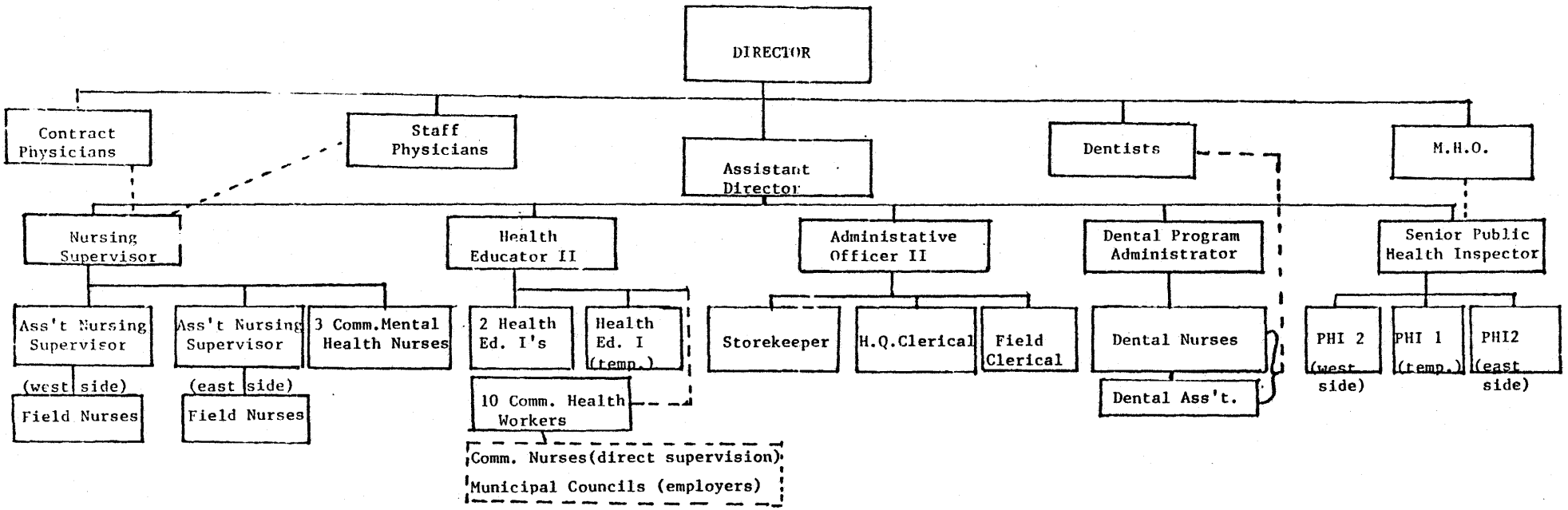
No.79 SEPTEMBER 1979. MONTHLY U.K.40p. AUSTRALIA $1.40. INDIA Rs.7.50. U.S. AND CANADA $1.50.



POPULATION

WHOSE PROBLEM?

APPENDIX E: HEALTH SERVICES BRANCH
ORGANIZATIONAL CHART



APPENDIX F: COMMUNITY HEALTH WORKER CONTRACT

THIS AGREEMENT, made in triplicate this of A.D. 19___.

BETWEEN:

Her Majesty the Queen in the Right of the Province of Saskatchewan, as represented by the Minister of the Department of Northern Saskatchewan

HEREINAFTER REFERRED TO as the "Minister" of the first part,

- and -

The _____ of _____, in the Province of Saskatchewan,

HEREINAFTER REFERRED TO as the "Community" of the second part,

- and -

_____ of _____, in the Province of Saskatchewan,

HEREINAFTER REFERRED TO as the "Worker" of the third part.

WHEREAS The Department of Northern Saskatchewan Act, S.S. 1972, c.34, and in particular S.4 provides that the Minister may provide health services to persons resident in the area mentioned in Section 6 of that Act;

AND WHEREAS the Community, established pursuant to the Northern Administration District Act, R.S.S. 1965, c.412, may pass such bylaws as it deems expedient for the provision of the health, safety and general welfare of the residents of the Northern Community area;

AND WHEREAS, the Minister and the Community wish to engage a Community Health Worker to promote increased health awareness and improve health in the Community and environs;

AND WHEREAS, the Worker, having been selected and trained in a manner mutually acceptable tothe Minister and the Community is duly qualified as a Community Health Worker and has agreed to provide the services described herein;

WITNESSETH THAT the parties in consideration of the premisesand of the covenants, agreements and conditions contained herein, mutually promise, covenant and agree one with the other as follows:

THE MINISTER AGREES:

1. (1) Subject to the terms and conditions of this Agreement to pay the Community for services to be provided by the Worker pursuant to this Agreement, the sum of not more than sixteen thousand ($16,000) dollars in any one fiscal year.

.....

(2) Payments payable by the Minister pursuant to paragraph 1 (1) heretobefore shall be paid in accordance with Schedule B. attached hereto and forming part hereof.

(3) Payment pursuant to paragraph 1(1) and 1(2), immediately preceeding hereof shall be subject to the satisfactory performance of the duties as agreed to by the parties hereto.

2. Subject to the Community's approval and Departmental policy and procedure, to compensate the Worker for actual expenses incurred in transport and travel in performance of duties according to the then current provincial government rates.

3. To be directly responsible for all non-salary expenses incurred in the operation of the Worker's program in accordance with this Agreement; such as postage, telephone, office supplies and health-promotion materials.

4. To provide at its expense, for the use of the Worker, such facilities, office space and equipment as it deems necessary for performance of the duties established under this Agreement.

5. Subject to the Provincial law, regulations and policies, and subject to whatever policy may be mutually determined by the Minister and the Community, to allow the Worker, where possible, use of Departmental vehicles in performance of the duties herein described.
In cases where the Worker is required to use a personal vehicle for this purpose, the provision of paragraph 2 herein preceeding shall apply.

6. To provide all professional training, supervision and support which it deems necessary for performance of the duties established under the Agreement.

THE COMMUNITY AGREES:

7. To employ the Worker to carry out the duties described in the Statement of Duties in Schedule A attached hereto and forming part thereof. and to pay the Worker a monthly salary in accordance with Schedule B attached hereto and forming part hereof.

8. To grant the Worker leave of absence with pay for:

(i) statuatory holidays
(ii) annual vacation, at the rate of 1¼ days per month
(iii) reasons of sickness, compassionate, or pressing necessity, at the rate of 1¼ days per month
(iv) the purpose of in-service training intended to upgrade the employee's job-related knowledge of skills; this type of leave shall be taken subject to prior approval by both the Community and the Minister.

9. To provide upon request of the Minister any or all records, accounts and related documents pertaining to employment of the Worker, for audit purposes.

THE WORKER AGREES:

10. To carry out during the continuance of this Agreement the said duties described in the Statement of Duties, set forth in Schedule A, attached hereto, which forms part hereof and to comply with reasonable directions of the Community.

.....

THE MINISTER AND THE COMMUNITY AGREE:

11. That direct day-to-day supervision of the Worker and program activities be by the local Department of Northern Saskatchewan nurse --- in the case of more than one nurse, by the one designated for this purpose by the Minister; that further administrative support and comparative (in relation to similar programs in other communities) guidance be provided where possible by a Department of Northern Saskatchewan "Community Health Worker Co-ordinator"; and that general policy or strategy guidance for the Worker's program be determined mutually by the Minister and the Community.

12. To participate as may be required from time to time, in joint assessment of the Worker's performance and the success of the program in meeting its objectives --- whether by comparison of reports, discussion at meetings or some more formal method of evaluation.

13. To facilitate the continuing education of the Worker through in-service training opportunities intended to upgrade skills and increase the employee's effectiveness; such opportunities may include attendance at brief courses, Departmental staff conferences and such.

14. That, if or as it may prove necessary, discipline of the Worker be carried out subject to their mutual agreement by a procedure and according to criteria acceptable to them both.

THE COMMUNITY AND THE WORKER AGREE:

15. To meet together, with the supervising nurse, regularly through the year, at least quarterly and if possible monthly, to discuss matters of health in the community, the program and performance of the Worker.

THE PARTIES AGREE THAT:

16. (1) The term of this Agreement shall be for twelve (12) months commencing the first (1) day of April A.D. 19___ and terminating the thirty-first (31) day of March A.D. 19___, subject to earlier termination as hereinafter provided.

(2) The Agreement shall be automatically renewable for further term(s) of twelve months, subject to the terms and conditions of this Agreement.

(3) The parties may by mutual agreement terminate this Agreement at any time.

(4) Any party may on thirty (30) days' written notice to the other parties terminate this Agreement at any time.

17. This Agreement shall be automatically terminated upon the happening of any of the following events:

(a) the insolvency or bankruptcy of the Community;

(b) the failure of any party to fulfill any of the terms of this Agreement, provided the party in default has been given ten (10) days notice of which to remedy such default.

18. Upon termination of this Agreement, it is understood that the Minister shall be obligated to provide the Community sufficient funds to permit it to pay the Worker up to and including the effective date of termination; and alternatively, that the Community is obligated to return to the Minister any funds already advanced to it but not owing to the Worker. It is agreed that in both respects, obligation to pay shall be limited to that for which an invoice has been received prior to the effective date of termination.

19. Service of any written notice as provided for by this Agreement shall be served as follows:

(i) Service shall be upon the Minister by personal service on the Minister of the Department of Northern Saskatchewan, his Deputy, or such other person(s) as may be designated by the Minister to accept service of the same or by registered mail addressed to the Department of Northern Saskatchewan, Box 5000, La Ronge, Saskatchewan.

(ii) Service shall be effected upon the Community by service on any of its officers or by registered post addressed to the registered office of the Community.

(iii) Service shall be upon the Worker by either personal service or by sending it by registered post to the last known address of the Worker.

20. This Agreement is not assignable.

21. Should any disagreement or dispute arise between the parties to this Agreement, it shall be referred to a board of arbitration, pursuant to The Arbitration Act, R.S.S. 1965, c.106.

22. Notwithstanding that it is the intention of the parties that this Agreement express the whole of the contractual relations between them, hey may mutually add to, delete, vary or amend the terms by reciprocal correspondence specifically to that effect, without the necessity of formally renegotiating this Agreement.

23. That no employer/employee relationship exists or shall be deemed to exist between the Worker and the Minister.

IN WITNESS WHEREOF THE PARTIES HAVE HEREUNTO AFFIXED THEIR RESPECTIVE SEALS AND SIGNATURES, THE DAY AND YEAR FIRST ABOVE WRITTEN.

SIGNED, SEALED AND DELIVERED:

- SEAL -	DEPARTMENT OF NORTHERN SASKATCHEWAN
	_____ Per
- SEAL -	COMMUNITY
	_____ Per
	_____ Per
WITNESS	WORKER
_____	_____
_____	

STATEMENT OF DUTIES

1. That the objectives and duties of the Community Health Worker be summarized as follows:

   (1) To assist the Community to identify needs for measures to improve its residents' physical, mental and emotional health.

   (2) To provide health-related information, instruction and guidance to the Community and its residents.

   (3) Through meetings, promotional campaigns, home and school visiting and other methods, to demonstrate and encourage good practices of health and hygiene.

   (4) To assist in furthering programs, especially preventive, conducted by Department of Northern Saskatchewan and other agencies to improve community health: particularly prenatal, maternal, child-care, nutritional and environmental.

   (5) To act not only as linguistic translator but also as interpretive liaison between community people and government staff: to explain local ways, conditions, problems, and needs to health staff, and to advise people of and explain to them the health-related activities, facilities and services available from the Department of Northern Saskatchewan and other sources.

   (6) Through reports to and meetings with both parties, to serve as a bridge between the Community and the Department of Northern Saskatchewan so as to further their mutual concern about and efforts to improve the standard of health in the Community.

   (7) In the absence of a more professionally qualified person, to provide to the best level of his or her training and ability, basic first-aid treatment which may be required, and/or to authorize (on behalf of the Department of Northern Saskatchewan) and help arrange medical emergency air transportation of a patient, such as may be required in particular circumstances, to a location which has appropriate health staff and facilities.

2. That the performance of the duties herein shall be on the basis of a thirty seven and one quarter (37¼) hour work week, and that this be considered full-time work: Work week, Monday to Friday, the Worker shall neither be required nor entitled during work time to carry on activities other than those closely related to the responsibilities outlined above.

STATEMENT OF PAYMENTS

1. The Worker shall be paid by the community a monthly salary in the amount determined as follows:

   (i) The equivalent of the monthly salary currently set by Saskatchewan Public Service Agreement for the job classification of "Assistant Social Service Worker", allowing further for whatever increment the employee may be entitled to for years of service according to that classification's scale; plus the equivalent of the monthly Northern District Allowance currently set by the Saskatchewan Public Service Agreement for the Community in which the Worker is employed.

2. The Minister shall quarterly, in advance of the first date when payment is due to the Worker, provide to the Community an amount equal to the Worker's salary as determined by paragraph 1 (i)-above --- plus the employer's contributions in respect of the Worker's Canada Pension Plan, Unemployment Insurance, and Worker's Compensation.

3. The Community shall be responsible as employer for such deductions from the Community Health Worker as shall be applicable in respect of income tax, Canada Pension Plan and Unemployment Insurance.

4. The Minister may provide upon request, as it deems necessary and in accordance with Departmental policy for its employees, a repayable advance for use by the Worker to cover travel expenses.