THE COMMUNITY HEALTH REPRESENTATIVE
IN ALBERTA--A PROGRAM EVALUATION

by

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to the required standard

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Date October 11, 1977
The Indians of Alberta sustain levels of health and well-being well below that of the average Canadian. Recognizing that the traditional health care system required modification for the special needs of Indians, Medical Services Branch of the Department of National Health and Welfare set up their first training program in 1962 to prepare Indian public health auxiliary workers, called Community Health Representatives. The hope was that the program would, among other things, allow Indians to be more involved in their own health care, extend the coverage of the health services and act as a vehicle to further community development of Indian reserves.

To evaluate this program, the general objectives of the program and the job description of the CHR's were used to derive short-term objectives which were examined on visits to reserves. Quantitative data were not available for assessing the achievement of objectives, but interviews and observations allowed a qualitative assessment of the program's effectiveness. The activities of CHR's and Medical Services in this program were examined in the context of their "environment" - the geographic, biological, psychological, sociological and anthropological factors which are both the cause and the effect of the health status of a people. From this very broad standpoint, a critique of the effectiveness, and the policy and direction of the program was offered.

The CHR's were found to be functioning in varying modes, with varying levels of effectiveness. Most carried out traditional public health nursing, acting mainly as assistants to the nurses. A few had a more political bent and were involved with committee work, the Band
Council and general development on the reserve. Health services may be extended by this program, but the goals of community development and community involvement in health care are achieved to a markedly less extent. Several situational and policy variables which may account for this are put forward.

The program is seen to be too small and too isolated from wider events in the political and health spheres to have had any great impact on Indian development and health. The resources available to the CHR program from within Medical Services have been scant, and the program has developed few relationships with outside agencies, especially a similar provincial program. The political and social isolation of Indians in Canada is echoed by the isolation of this program within the Department of National Health and Welfare and the province. The program's potential of improving Indian health, of acting as a lever to general development, of encouraging Indians to train and work in the health field to eventually have Indians in control of their health service, has not nearly been met.

The political uncertainties surrounding Indian affairs make it difficult to foresee the results of any decisions. However, if the Indian health service and this program eventually become the responsibility of the province, the scope and circumstances under which it will be operating will broaden. The advantages of having the large provincial service's resources available to the program will be great, and the possibility of closer integration with Indian and regional development will arise. The most precious asset of the program, its flexibility, its ability to adapt to individual communities, must be carefully maintained. Thinking about these potentials and preparation for such changes should start now.
To my family and friends, and to my supervisors—without whose help I could not have gotten by.
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My greatest debt of gratitude is owed to the Indian people who patiently shared their knowledge with me and helped me to understand the significance of the events they described. Much thanks is also extended to the field personnel of Medical Services for their unfailing hospitality, and willingness to give information and take part in vigorous discussions, which gave life to statistics and scholarly literature. Many of their names appear in the citation of sources in the footnotes or in the appendix of interviews.

I would also like to thank the staff of the regional headquarters of Medical Services in Edmonton for the opportunity to read their records and reports and discuss them with them, especially Dr. Kirkbride and Dr. Shedden.
Moral and financial support for this thesis is gratefully acknowledged from the Canadian University Overseas Service Raya Pearlman Scholarship, and from Mr. Fran Brunelle of the Alberta Department of Social Services and Community Health.

It remains only to add that I myself am responsible for any errors, omissions, inconsistencies or idiosyncrasies that remain.
INTRODUCTION

A. PURPOSE AND ORIENTATION OF THE THESIS

In 1962 at Norway House in Manitoba, the first training program to prepare native people as public health auxiliary workers was completed. Eleven native people returned from this program to work on their reserves. The program, called the Community Health Representative Program, has continued and expanded in Alberta up to the time of this writing.

The purpose of this thesis is to examine the written objectives of the program to determine to what extent it is meeting its manifest objectives and to discuss some of the factors behind the direction of its activities. From this basis, implications for the future development of the program will be explored.

The impetus to choose this subject for a thesis arose from the writer's experience as a nurse-educator in a multilingual developing country, where the delivery of health services is implemented to a large extent through auxiliary health workers. The similarities between this developing country and certain areas of Canada, notably those where native people predominate, impressed the writer with the feasibility of using such workers in the northern and largely native areas of Canada, even though she has had little direct experience with providing services to these areas. The wide scope of responsibilities and roles which can be taken by auxiliary workers has certain implications for the administration, supervision, and education of such workers, and open up exciting possibilities for extensive native involvement in health care delivery.
The stated motive behind the auxiliary health worker program in Canada is that of raising the health status of native people to a level as close as possible to that of the rest of Canadians. Strenuous efforts to improve the general socioeconomic status of Indians are said to be a basic requisite to this end. An expansion of traditional health services is also necessary. But traditional health services are geared to meet the needs and demands of the majority of white, middle-class Canadians, and native peoples are a minority, with different characteristics. Innovative adaptations to suit the needs of natives are also required of the delivery system.

Weidman and Egeland\(^1\) argue as a basis for establishing an effective health delivery system that attention be paid not only to the usually considered geographic and environmental factors, but also to four other perspectives: biological (symptoms, disease), psychological (stress, personality), anthropological (cultural, ethnic), and sociological (class-structure and function). These four perspectives were used in the context of both historical and current political and social events to provide the basic framework for analyzing the functioning of the health auxiliary program in Alberta.

B. BIOLOGICAL AND PSYCHOLOGICAL PERSPECTIVES

Numerous studies document the poor health of native people in Canada. A quick examination of gross statistics collected by Medical Services of the Federal Government comparing Indian with national health indicators makes obvious the disparities. Briefly, infant mortality and
tuberculosis, considered to be sensitive indicators of health status, and for which figures are among the more accurate of health statistics, show rates of two to three times the national rate for infant mortality and ten to fifteen times the rate for tuberculosis. A high incidence of infectious disease, suicide, congenital anomalies and accidents give compelling evidence of the gap which exists between the health levels of natives and those of Canadians in general. Especially telling are the high rates of alcoholism and suicide, which according to one interpretation, represent a retreat from the "vicissitudes of life, a failure in his mechanisms of adaptation and an escape from reality."

C. SOCIOLOGICAL PERSPECTIVES

"Socioeconomic status is a theoretical concept still awaiting clear definition". Many variables such as occupation, family income, living conditions, social prestige, social deprivation, cultural disorganization and combinations of these have been used to describe socioeconomic status. By any of these criteria, the native people of Canada occupy the lower strata of society.

In economic terms the present situation of the Canadian Indian Reserve communities is comparable to that of underdeveloped countries.

Where the average Canadian family of 3.7 persons share 5.3 rooms, the average Indian family in Canada must find space of 6.4 people in 3.6 rooms - a complete reversal of the national average.
The infra-structure - the common mechanical ingredients needed for both social and economic health of a community - reflect the same disparity with the national picture. For Indian homes across Canada, there are 79% with electricity, 31% with running water, 24% with indoor toilets, 19% with indoor baths, and 25% with telephones. This contrasts with 98% of houses with electricity; 97.4% with running water, 96.1% with indoor toilets; 93.5% with indoor baths and 94.3% with telephones across Canada. 5 (p. 7).

Unemployment levels are high and chronic dependence on welfare all too common.

Nearly 50% of the Indian population is unemployed and living on relief; ten times the national average. 6 (p. 6)

Educational levels are low, with less than 90% of Indian children completing Grade 8; and 6% completing high school, compared with 88% for the whole of Canada. 7 (p. 6)

All these features are both a result of and a cause of the lack of achievement of good levels of health and health care. But there is another aspect to socioeconomic status not measured by these data.

Poverty in its truest sense is more than mere want: it is want mixed with a lack of aspiration and this is very difficult to measure in any quantitative sense. 8 (p. 6)

Oscar Lewis' "culture of poverty" has as its core despair, in a cycle of hopelessness, ill health and impoverishment, each reinforcing the other. Loss of self esteem and feelings of powerlessness and
apathy create dependency on impersonal agencies to make wide-ranging decisions for clients.\(^9\)

At present, rather than being the designers and judges of their own economic destiny, Indian people have been the root of big business employing civil servants, consultants, outside merchants who have been the chief beneficiaries of large appropriations voted for the purpose of aiding the development of Indian communities.\(^{10}\) (p. 4)

The statements of Indian leaders quoted above leave no doubt that the Indian people feel themselves that they share in many of the characteristics of poverty variously defined.

Strauss,\(^{11}\) in a recent article, juxtaposes the life-style of lower-income groups with the life-style of the middle-class people to which the health delivery system is oriented. He claims that the dichotomy alters the delivery of care to, and utilization of services by, people from these groups. To achieve better fit between these groups, he puts forth six proposals: to speed up the initial visit made by lower-income groups for health care, to improve the experiences which the patient has in health facilities, to improve the communication given and received about any necessary regimen, to increase the likelihood that the regimen will be carried out at home, to increase the likelihood of necessary revisits to health facilities, and to decrease the time between the necessary revisits for care.

In all of his recommendations other considerations besides
"lower-class" culture are implicit: he also calls for knowledge of and sensitivity to ethnic groups, their values and beliefs, and the social and cultural context in which they operate.

D. ANTHROPOLOGICAL PERSPECTIVES

The health care of a people, the phenomena associated with the maintenance of well-being and the coping with illness, emphasizes not only the beliefs and practices of a people, but also the pattern and function in a culture. A striking feature shown by ethnographic studies on health culture is the utilization of several competing health treatment alternatives by people, each supported by a different value profile. This was true for very few other social institutions studied (economy, education, policy) which had clear-cut patterns for the life situations. The practitioners of "modern medicine" also derive from a health culture with its own assumptions, categories and schemata and this is another source of Strauss' "mismatching".

When the "out" group introduces a health program into a community, the members of the community may be expected to actively choose between it and any alternatives. Problems commonly cited by health care deliverer such as the non-recognition of the significance of disease signs, the non-utilization of resources and the non-acceptance of preventive health practices, point to a far from smooth process of fit between the two cultures.
Elements which characterize Plains Indian culture such as a dependence on nature and a fatalistic passive acquiescence to it, the lack of developed political organization, and the economic independence of families, engender a sense of emotional isolation, emphasis on the maintenance of the status quo and a reluctance to exercise authority and ascendancy over others outside the nuclear family. This conflicts with the bureaucratized, corporate organization of industrial society which emphasized activity, mastery of the environment, upward mobility and concern for material well-being.

The overwhelming direction of acculturating forces have undermined traditional cultures, to the extent that the culture which now exists is a "reserve" culture. Slobodin states that the great changes occurring especially since World War Two, the disappearance of almost all traditional occupations, techniques and artifacts, and the weakening of such aspects of culture as language and ritual, have suggested to some observers that terms as "Indian" are no longer suitable as an identification for many groupings of their cultures or subcultures. (p. 289)

He also states that there is little comprehensive information about the nature and identity of Canadian Indian groupings today but asserts that Indians living away from their ancestral groupings are undergoing more extensive and more intensive acculturation than the land-based groups. Similarly, such gross measurements of acculturation as
language spoken, educational levels reached and occupation held suggest that the Indians of Alberta are acculturated to varying degrees. All of these considerations point to the advantages of a flexible individualized approach to Indian communities and programs for them. It is the local group, rather than the large taxonomic category "Indians" that has meaning for health deliverer.  

E. POLITICAL AND SOCIAL MOVEMENTS

The Indians of Canada can be considered a minority group, defined in Wirth's terms as "a group of people ... singled out" from the others in the society in which they live for differential and unequal treatment. The existence of a minority group by definition implies the existence of a privileged dominant group of high social status.

Lieberson points out that the subordination of indigenous groups and the dissolution of their previous forms of organization are responsible for the creation of racial consciousness among the indigenous population. He says considerable conflict occurs in areas where the migrants are not simply superordinate, but have become in a sense themselves indigenous by maintaining an established population through generations i.e. have become the majority.
The 1960's saw a newly awakened world-wide consciousness of people living in social, economic and cultural misery. In the United Nations, the 1960's were declared the "Development Decade". In North America, the burgeoning political movements among the Indians, the statement of Canadian federal Indian policy in 1969, and the investigations by the Senate and other groups into the nature of poverty in Canada led to a movement aimed at allowing the natives a larger voice in their collective fate. A growing consciousness of the need to be sensitive to the wishes of ethnic groups and to develop adaptations of traditional programs fostered new approaches to the "Indian problem". One approach to meeting the needs of depressed areas was to use indigenous non-professionals as workers in various fields. As Roberts states, consumers of services became motivators and providers, rationalized by skill based on culture, feeling and communication, rather than training and knowledge. A service offered by a peer in language, ethnicity, background life-style and interests could be more effective, it was supposed, than that offered by a professional. At the same time, it was recognized that service occupations could be organized more efficiently by breaking jobs into hierarchy components which could be provided by people with different degrees of training, and that training could be provided largely by systematic on-the-job experiences.
F. A REVIEW OF THE COMMUNITY HEALTH REPRESENTATIVE PROGRAM IN ALBERTA

The traditional and conventional methods of health care had raised the health of most people of Canada to a high level, comparable to other industrialized countries. However the native people had apparently not benefitted fully from these approaches, as indicated by the high levels of ill-health and social problems among them.

As a result of the movement towards greater Indian involvement in their own affairs, the federal government set up a program in 1962 to train and employ treaty Indians as community health representatives. There were 18 employed in Alberta, with another 26 taking their initial training in the summer of 1975.

An initial survey of professionals, organizations and government officials' knowledge about this program indicated some confusion over the program objectives, and about the roles, duties and responsibilities of such workers. Controversy also existed over their effectiveness and efficiency. Uncertainty as to the future need for such workers, and trends occurring in the U.S. especially regarding the careers and training of para-professionals, suggested that a review of the program would be opportune at this time.

The review was divided into several steps. The first steps

* There are only three nations in the world, Sweden, Norway and the Netherlands, which have a greater life expectancy for females than Canada, and the difference between Canada and the best nation is only one year. For male life expectancy, there are six countries ... and the gap between Canada and the best nations is 2\frac{1}{2} years. 21
were to determine if the needs and concerns which the program was intended to serve had been adequately identified, and to determine who had been involved in defining the needs and setting up the program. These needs were presumed to be the basis of the program objectives which were then examined on several counts: their authors, their agreement with over-all objectives of Medical Services, their appropriateness to the needs and expressed wishes of Indian communities, and their measurability and feasibility of achievement. Next, various criteria for measuring the achievement of these objectives were proposed as the basis for assessment of the effects and effectiveness of the program. Both the objectives themselves and the criteria for measuring achievement of objectives were then analyzed from the context explained earlier in this chapter: a health delivery system should take account of geographic, environmental, biological, psychological, anthropological and sociological factors in its policy and implementation. The implications of past actions and present directions were explored, with recommendations offered for the future.

It is hoped that this sketch of the basic framework used in the thesis will provide sufficient background for understanding the approach taken and the interpretation placed on the data collected. Quantitative data for assessment of the program were not available, and examination focused as much on the program context and the general orientation revealed by program activities
as on the actual achievements of the Community Health Representatives. These activities and achievements should ideally be the subject of further research in more depth than would be managed in this thesis.
A. THE PLANNING PHASE

In the latter part of the 1950's, both the Indian Affairs Branch of the Department of Citizenship and Immigration, and Medical Services Directorate of the Department of National Health and Welfare were seeking fresh approaches to meeting the problems of Indian communities, in the face of disappointingly slow development up to this date. For various reasons, both departments had been discussing ways to train more Indians to work in their own communities in the fields of education, health, welfare and general and economic development. It was hoped that such programs would be an economical means of alleviating some of the massive problems facing native communities in the light of inadequate financial resources. Indian workers would form a cultural liaison between white professionals and natives, and help to tailor programs and services to the individual communities. Increased interest in and knowledge about the principles of community development led to a realization that identification of needs as well as initiative in meeting these needs had sprung from local and indigenous roots, rather than being defined and tackled by outside sources.

As a result of meetings between the two departments in 1957 and 1958, it was decided that the Medical Services Branch of the Department of National Health and Welfare (hereafter referred to as "MS" or "Medical Services") would carry out a pilot project to train
and employ health workers. In 1960, a planning group in Ottawa Head Office, composed of medical and dental officers, a nurse, a nutritionist, an accountant, an administrator, a personnel officer and a health educator set down the principles of the Community Health Worker program. They outlined the criteria for areas where training was to be conducted, the number and selection of candidates, the duties of workers and of their employment after training. The goals of the program were also specified. Short-term goals were three:

1. to encourage the participation of local people in the health activities of their communities, by involving them in initiating, planning and carrying out programs;

2. to give professional health workers an opportunity to become more effective by providing a person who would liaise with the community; and,

3. to increase the number of active health workers in the field.

The long-term objective was to assist native people to reach and maintain a standard of health and living conditions comparable to that of the remainder of Canada's population.
A committee was also set up at the Regional level, in order to select the actual areas where candidates were to be solicited (generally those with large populations with a high incidence of disease), to arrange for the provision of training facilities and to provide administrative support. To this point, although Indians had long talked about employing their own people in community work, no mention was made of consultation with Indian leaders or communities, at least in the published reports and government documents seen by the author. It remained for Medical Services to explain the program to the Indians and to solicit their co-operation, as well as that of the other local communities and Medical Services personnel at Federal, Regional, Zone and nursing station level.

In the communities selected for health workers, the program was interpreted by the health educator and planning committee to Medical Services staff, Indian Affairs Superintendents, Reserve opinion-leaders and to Chiefs and Councillors who invited views from the community at Band meetings. Careful selection of candidates was recognized as one of the key requisites of a successful program. The importance of personal and leadership qualities in the applicants in preference to academic qualifications were explained to the Chiefs and Councillors. People who had the respect and trust of the
community, who were sensitive to its needs and who had already displayed resourcefulness and intelligence in community work, who were seen as 'helping persons', were to be selected and recommended by the Chiefs and Councillors. They were to be bilingual, literate and preferably married and settled in the community. The final choice was left to the Regional Planning Committee.

Eleven candidates were selected, four women whom it was considered would be assistants to the field nurses, and seven men who would focus on basic sanitation. Their functions were defined as follows:

1. They were to be teacher/motivators, who would acquaint their people with health concepts and techniques, and teach them the utility and function of the local health services, especially the preventive services.

2. They were to play a liaison role, helping clients to contact and use the appropriate services.

3. They also had an outreach/detection role, as they were to go into homes, and become involved in group work to determine needs and assist in meeting them.
4. Their job included helping the community to become more self-reliant in health matters. An advocacy/mobilization role was implied, where the worker, basing his planning on expressed community needs, was to try and ensure that the human service needs of the people were met by assisting community groups or government to develop new facilities, resources or programs.

Training and supervision after selection were recognized as the other cornerstones for the successful utilization of such workers. The field nurses responsible for orientating the new workers were prepared by literature explaining the program and their own role, along with a practical manual for the orientation period. They were expected to help plan the workers' training course and to be present during part of it as well.

B. THE FIRST TRAINING PROGRAM

In 1961, in Norway House, Manitoba, the eleven candidates received three months of instruction after a two-month orientation on their own reserves with their supervising nurses. Orientation was designed to give them a basic grounding in the 'facts' of their communities, to learn the roles of such people as the teachers, RCMP, clergy and so on, what resources were available to meet the different needs of people, and about local health conditions and
peoples's attitude towards them. Building on that foundation, the training course concentrated on techniques of teaching aids, communication theory, interviewing skills, and the work of government agencies. The trainees also studied the St. John First Aid Course and the women were given a course in home nursing. The whole program was designed to provide the candidates with information, to develop and reinforce attitudes considered appropriate for the work e.g. self-confidence, patience, independence, and to develop the skills regarded as necessary for community health work. After six weeks of general health education, the female candidates attended two weeks of discussions on public health nursing, and the males received practical training from the regional sanitarian.

On graduation, each trainee was presented with a certificate signed by the Minister of National Health and Welfare and the Director General of Medical Services. All were employed as Public Servants following the course. Another training program was held in 1963 and two more in 1964 and 1965.

1. First Evaluation

An evaluation was carried out in 1964 by a sociologist from the University of Saskatchewan, in accordance with a principle laid out by the Planning Committee of an-going evaluation
of the program. The author concluded that the program could be considered successful as a whole, on the basis that the communities had accepted an increase and diversification of the workers' activities. Little statistical measurement of the program was possible, but a certain amount of data on garbage pit and privy construction, and attendance at clinics was said to point to definite improvements.¹

Attention was drawn to the difficulties faced by the workers: the role of acting as a communication link between Medical Services personnel and the native people was constrained by differences in cultural and educational background and by a lack of fluency in English. This both restricted the amount of information a worker could assimilate and affected the smoothness of the social relations between workers and their supervisors. Furthermore, communication difficulties between the workers and their communities sometimes arose as a result of the Indians' traditional suspicion of white men's ideas and was augmented by the high turnover of nurses. The fact that the workers were relatives and friends of many people on the reserves, led to emotional entanglements complicating their work. Poor economic conditions made health a low priority on many reserves, and the longstanding lack of self-government worked against the people becoming involved in, and assuming responsibility for, their health services. The author felt that without stimulation and
encouragement from Zone and Regional levels of Medical Services, the program would lose its creativity and drive: existing back-up services and visits from these levels were said to be sporadic and inadequate. Workers were not always respected by whites outside Medical Services, teachers and Indian Affairs employees experiencing special difficulty in understanding their role.

The report suggested improved supervision of the workers, more communication between the workers themselves, improved working conditions (pay, transportation and teaching aids), increased publicity about the program on the reserves, improved collection and distribution of information on the program and alterations in the course content of the training program to cover such topics as alcoholism, school drop-out and family planning.

2. Further Evaluation

In 1966, Miss Ethel Martens,² the original instigator of the program, studied community development and health education programs for the Indian populations in the United States and Mexico. The broad regional approach taken to community development by the Mexican government was compared with the Canadian Community Health Worker program, in the light of the different geographic, economic, demographic and political conditions in the two countries. The author concluded that although the Community
Health Worker program by its encouragement of self-reliance in the health field might lead to the spread of such an attitude to other fields such as education and economic development, these effects would be of only secondary importance to the health department. The Mexican program involved all agencies of government in a region, in the belief that the integration and co-ordination of all government activities was necessary in order to integrate Indian communities into the life of the nation. Questions were thus raised as to whether the necessary high-level co-ordination in policy-making and execution was developing in Canada, and whether the Mexican experience in community development held some lessons for Canada.

C. CONTINUING DEVELOPMENT OF THE PROGRAM AND THE TASK FORCE REPORT

Further training programs were held in 1967-68. By that time there were 73 workers trained across Canada, and 63 were still working with Medical Services. In 1970, a number of changes were introduced into the program. The formal training was divided into two periods of eight weeks and four weeks, separated by six months of on-the-job training. The number of trainees was increased, so that all Regions had Community Health Workers. They were not made Public Servants once graduated, but were put on personal contracts with Medical Services, as an interim step to becoming Band employees (still, in 1975, an infrequent occurrence). By 1973, 47.9% of the male workers and 81.9% of the female workers remained, of a total of 212 workers trained in Canada.
When programs move from implementation as pilot projects to institutionalization on a large scale they commonly undergo certain modifications. This was true here, where program expansion led to relaxation of some of the principles originally laid down in 1960. The program had to be adapted to a wider variety of geographic, economic and social conditions. Greater emphasis on Band selection of trainees and pressure to obtain candidates meant that selection criteria were modified. Sufficient encouragement and support for all the workers was difficult to ensure, and some communities were not given adequate orientation to the program. Even though it was recognized that a certain amount of information had to be provided to communities, community leaders and Medical Services personnel in order to elicit their co-operation, efforts to this end were not always successful. Administrative and community enthusiasm fluctuated from very high in some regions to very low in others. Field nurses were ill-prepared for carrying out workers' orientation and on-the-job training; refresher courses were infrequent; cooperation between various levels of Medical Services was sometimes lacking; and Community Health Workers expressed dissatisfaction with their pay and fringe benefits.

During the 1970's the numbers of nurses, health educators and Environmental Health Officers employed by Medical Services had
increased substantially, as did the number of local, native workers operating on the reserves in health and other fields. Indian organizations had become more vocal, and many Bands had attained more self-government than previously. In the absence of administrative clarification and co-ordination, changes in the roles of Medical Services personnel resulting from the altered environment were confusing and variable.

These growing pains of the 12 year-old program and the need for "new horizons" for Community Health Workers were the subject of a Regional Conference held in Ottawa in February, 1972. This led to the establishment, in May 1972, of a Task Force on Community Health Auxiliaries. Its purpose was to develop new Community Health Auxiliary roles that would assist Medical Services to achieve its ultimate objective of making native standards of health and well-being comparable to those of the rest of Canada. By October, of that year it had recommended Branch policy for the direction and training of Community Health Auxiliaries, and had outlined medium and long-range implementation plans.

One of the major recommendations was that two Community Health Auxiliary roles be established: a Community Health Representative whose main orientation was to the community, and a Family Health Aide whose main function was toward the individual and the home. These workers would be employed by Band or Hamlet contract.
The principles of career development and progression were laid out, from a first-level probationary worker to the fourth level of Community Health Auxiliary Advisor. A minimum amount of refresher or advanced training was to be a condition of continued employment. More formal mechanisms to evaluate workers' performance was urged as well as a program to encourage native people to work in the health professions with Medical Services.³

D. RECENT DEVELOPMENTS IN ALBERTA

In the two and a half years since the report was promulgated, a number of the recommendations have been followed, and others have been honored more in the breach than in the observance. In Alberta, the two distinct roles for auxiliary workers exist, and the training program for the two, while having most elements in common, diverges along certain lines e.g. the Family Health Aides receive more instruction on the use of many drugs. The workers have resisted any move to become Band employees, and the Bands themselves have not evinced any great desire to take over the administrative responsibility for these workers. The idea of career progression has not moved beyond the two stages or probationary and full employee, though in the summer of 1975, plans were being made in Alberta Regional Headquarters to have two Community Health Worker Co-ordinators as advisory personnel to Headquarters staff and to nurses working with auxiliary workers. The hope of providing more continuing education for the workers seems to have dimmed with the resignation of the Alberta Region Health
Educator in the summer of 1975, with no replacement planned. Additionally, ways to finance transportation for workers are being sought, but financial restrictions make this unlikely in the near future.

Twenty-four new workers, mainly in the Community Health Representative category, were given a 4-week training course in Edmonton in August 1975 by a field nurse drawn temporarily from her usual work on a reserve near Edmonton. All the nurses who had orientated these workers for the previous two months and who would be supervising them hereafter, were urged to attend the course for a few days to find out something of the course content and the role of such workers. However, only three of twenty-four attended. The workers returned to their reserves for a probationary period of six months before the second half of their formal training course. The nurse-trainer also returned to her usual duties on her reserve and expected to be able to have little or no contact with the new workers or their nurses until the next training period, in January of 1976.

The opportunity for the author to look into this program arose when she worked in 1976 for the Alberta health department in Edmonton, where the provincial and federal governments both have headquarters for their auxiliary worker programs. This examination of the use of auxiliary workers for a minority group in a developed country, comparing it to previous experiences with such workers in
a developing country, highlighted for the author the similar opportuni-
ties and difficulties experienced by such health workers every-
where. The basic principles for the training and employment of
auxiliaries are the same, and useful lessons can be learned by
following the progress of these programs in different regions and
countries. Such was the curiosity that led to a program evaluation
of the Community Health Representatives in Alberta.
CHAPTER II

PROGRAM EVALUATION

A. EVALUATION: GOALS VERSUS SYSTEMS

A program is a set of related activities carried out by an organization to achieve some purpose or purposes. One type of evaluation study examines the ability of the program to achieve its objectives - the "goals measurement" evaluation. A set of dimensions are chosen as criteria by which to measure the organization's actual performance against the "ideal" performance (i.e. goal achievement) of the program's activities. This is one measure of effectiveness.

A second approach is found in the 'systems' school of thought, which focusses evaluation attempts on the related activities of a program, as well as its purposes. Effectiveness in this approach is defined as the optimal allocation of resources between achieving the program goals, co-ordinating the organizational sub-units, acquiring and maintaining resources, and adapting to the internal and external environment of the organization, all of which are necessary for organizational effectiveness. 1

1. Goals Measurement

The more commonly used method of evaluation of effectiveness is the measurement of goal attainment. It is supposed to remove the evaluator's bias, as he must use "objective" criteria to judge the organization i.e. its goals. Nevertheless, goals are normative in the sense that the evaluator reports what the goals are, or should be,
as dictated by the consistency of his personal theory about the relationship among parts of social systems. This model also makes, as Etzioni\(^3\) points out, two assumptions: that organizations have an ultimate goal which they wish to realise, and that the ultimate goal can be identified empirically and progress towards it measured.

Although goals give a good set of clues as to the organization's primary orientation, they may also idealize, rationalize, or omit some aspects of the organization's functioning. Goals may be public or private, and the organization may be pursuing either or both. Organizations may also seek to perform a number of conflicting goals, and those working in the organization may also have varied goals. Finally, those receiving the services and the wider public may agree or disagree with any of these goals. The evaluator must determine which of all of these goals are being realized and indeed, if they are meant to be realized. He must also determine from observing the organization's activities if there are undeclared or informal goals being pursued, and evaluate effectiveness on that basis as well. This provides an obvious way for evaluators to introduce their own biases. As Yuchtman and Seashore\(^5\) point out, it is difficult to separate private goals from effect, for people
learn to pursue realistic goals which they realize and from which they receive positive reinforcement. For example, if growth is difficult, the organization will pursue goals which are non-growth-oriented.

These comments are germane to this study, for the goals of the program as set out by Medical Services, supplemented by objectives the author inferred from the CHR job description, (see Appendix 3, 'Job Description for CHR's') have formed the basis of the analysis. The author assumed that Medical Services was trying to achieve the written objectives and then considered the measurement of progress to these ends. As well, the assumption that having such workers requires a certain administrative framework for their training and back-up has led the author to analyze the program from that basis as well, even though no written objectives concerning these areas were seen by the author.

The goals may be examined as goals-in-themselves; that is, as regards their tie-in with superordinate program goals, their basis on scientifically valid and adequate evidence, their measureability and their feasibility of achievement, conflicts inherent in them and so on. In terms of actual achievement of goals, the long-term end results of such programs as the Community Health Representative program, i.e. the 'effects' on morbidity and
mortality, are inconvenient for practical purposes of program evaluation. Even if such results could easily be measured, it is obvious that many organizations do not reach their ultimate goals. This is not to say that organizations should immediately be branded as having 'low effectiveness'. They can be evaluated also in terms of immediate or intermediate goals, as the former are, in a well set-up program, the intermediary steps on the way to the ultimate goals. They give an idea of effort, or the immediate objectives of establishing a service, such as a certain number of clinics. They can also give an idea of performance or accomplishment, such as the number of people with visual problems detected. Assuming that some of the needs existing in a community are known, as impression of the appropriateness of the work being done is possible. In this way, i.e. measuring short-term means rather than long-term ends, the measurement of a program's effect can be approached. This is however, one of the important criticisms of functionalism: means tend to become ends, and the provision of services is assumed to result in benefits, not a proven association in all cases.

Some cautions must be added. Social action and public health programs may be more concerned with their impact on a situation and only secondarily on individuals. They do not often produce dramatic impacts, requiring either very sensitive indicators or else very large samples. Where goals are explicit
and knowledge about important relationships is good, the assumption that an activity leads to an effect is reasonably valid. Public health programs and preventive medicine frequently suffer from just this lack. If a program is to alter the natural course of a disease, the natural history of the disease must be known, and the points at which intervention will alter it as well. For many diseases, and certainly for various social problems such as delinquency, the points of intervention and effects are not known.

The temptation with the goal model is to focus too narrowly. If a number of people are subjected to the same intervention with a clear-cut outcome, the measurement of goal achievement is useful. But the situation in which a program takes place is essentially uncontrolled i.e. a community is open to a host of influences besides the program, and the program will differ somewhat in each community. The outcome of programs is affected by the staff and site of the activity, as well as the activity itself. It is thus more realistic to speak of an agent as altering the probability of an occurrence rather than causing an occurrence. As well, using a strictly experimental design of planned - output measurement discourages the perception or inclusion of unanticipated consequences which may be just as or more important than the anticipated ones.

All of these difficulties are reasons for the frequent
use of service statistics for evaluation purposes, in which the means of a program rather than the ends are emphasized. Means seems to be inherently more quantifiable, and this carries the danger of course that the final goals will be lost in carrying out the 'letter' of the means. But often the lack of knowledge or resources to do a more comprehensive evaluation means that the means are measured and goal achievement surmised.

2. **Systems Analysis**

Systems analysis starts with a model of a multi-functional social unit which is capable of reaching a goal. The unit is one of a set of units which interrelate and operate together in some sense as a bounded larger unit. That is, a system consists of subsystems which fulfill the conditions of systems in themselves, but which are also functional components of a larger system, or the suprasystem. Each subsystem must interact with and adjust to the others. Because each system (or subsystem) must maintain some discontinuity with its environment, it has boundaries across which it interfaces with other systems. Matter, energy, information and people pass across these boundaries. Environment, or the surroundings of a system minus its suprasystem, is an important variable since it interacts with and affects the organizational system, and vice-versa. Different environments call for different strategies and responses if the organization is to be effective. But there are problems in defining boundaries and environments. Boundaries can be physical, or can be
defined in abstract terms of clusterings of behaviour or interactions. An environment can be described in terms of the objective realities of it, the system's perception of it, those elements which are relevant to goal attainment, information which the system uses to function, and in various other ways.

This is one of the major difficulties in using the systems model. It requires that the evaluator set up a working model of a goal-attaining social unit and determine what he considers to be the optimal allocation of means within that unit to meet the four activities necessary for organizational effectiveness as described above. It requires considerable knowledge of the way in which an organization of this type functions. Organizational theory, in its present stage of development, often does not provide a model of this type for use in evaluation. The difficulties of defining boundaries and environments would have to be met by setting very arbitrary criteria which would affect outcomes of the evaluation. For example, with the Community Health Representative program, all of the Representatives could be considered as one subsystem, and all of the nurses as a separate subsystem, or all of the Representatives and their nurses with whom they work so closely could be considered as a subsystem. Either the various communities in which the workers function, or Medical Services could be considered as the environment. The Branch of Medical Services in the
Department of National Health and Welfare in the federal government could all be considered as various subsystems, or as suprasystems, while the provinces in which the program is carried on would be part of the environment of some of these subsystems, and the provincial governments part of the environment, or else a suprasystem for which elements of the program are subsystems. The nebulous nature of the concepts and the lack of empirical knowledge afforded by organization theory makes this model very demanding and difficult to use. The 'system' is almost undefinable for practical purposes of evaluation.

Systems theory adds some valuable points for consideration by noting that effectiveness is a function of the work to be done, and the resources and techniques available to do it. This is another reminder of the need to evaluate the feasibility of goals.

The environment must be carefully taken into account, the processes by which an organization copes with its environment, solving problems in adapting to changing conditions. For example, program goals must be considered legitimate by the superordinate organization; they must be evaluated in terms of their priority of attainment for the superordinate organization. But health programs are also in the position of having to motivate the "subordinate" organization i.e. in order to succeed, the program must be legitimate in the eyes of the consumers or recipients of the service. Because much of the
success of a program such as this depends on behavioural change, Medical Services was anxious to obtain Indian participation in setting up the program and validating its goals. The internal environment, such as the relationships between Medical Services, auxiliary workers and nurses, the organization's methods of obtaining and maintaining their resources e.g. trainers and auxiliary workers, and so on, are also than a necessary part of program evaluation. The systems method could be seen as useful help for spotting problems and bottlenecks if a program does not appear to be meeting its objectives.

If these program elements are considered i.e. goals, effort, performance, process and environment for a standardized activity, as well as actual output, the measurement of effectiveness of program activity falls between the systems approach and the goal-attainment-only approach.

B. A COMBINED APPROACH TO EVALUATION: THE METHODOLOGY

The main focus of the study was on attempting to understand the environment in which the program operated and the dynamics of the situation, internal and external, which affected its outcome. That is, the emphasis was on process in the program, rather than outcome. Policy and situational variables were considered as important as outcome variables.
The environmental context of the program was analyzed by reviewing among other things, the history of Plains Indians since contact, and the history of the CHR program, anthropological literature on Indian culture and sociological literature regarding minorities, class-culture conflicts, community development programs, and evaluation methodology. Internal dynamics were examined by using organizational theory re management and work structures, educational theory on para-professional workers and insights from psychology into interpersonal and intrapersonal functioning. These reviews helped to throw light on policy and situational variables affecting the program.

The goals of the program were examined more as goals in themselves — their feasibility, appropriateness, inherent conflicts — rather than concentrating on their achievement. They were considered to be revealing of general policy, and helpful to understanding of the processes operating in the program when studied in conjunction with the political, social and cultural context of the program.

Using the broad goals of the CHR program as written by Medical Services, and the CHR's job description, the author derived more intermediate and immediate objectives which could be observed and measured, and which were felt to be logical steps toward the broad, over-all goals. It was noticed that even though objectives
were written for the program, there appeared to be considerable divergence among the field nurses and workers as to their goals, so that some emphasized one to the exclusion of others, or interpreted them differently. The workers' performance would then have to be examined in the light of these different situational contexts. Preliminary interviews at Medical Services revealed that the exact effects of the program were not being predicted by either the administration of Medical Services or by the field personnel, since efforts were seen to vary with the personality of the nurses and workers, the political and economic climate on the reserves, the amount of contact between the Indian and white communities, past experiences with such workers, and other variables. These situational variables were considered to be very important, and were the reason for the extensive review of the literature.

Standardized and separate records are not kept by MS for the CHR program, either for the work done by CHR's or for the resources put into the program. Separate financial accounting records are not kept and personnel concerned with their training and supervision have other tasks as well, so that it is possible to gain only an impression of resource input, the 'spirit' of the effort.
Roos feels that a descriptive monitoring may be most appropriate if there is little agreement on objectives, or if there is little understanding on the affect the program is likely to have, where the anticipated effects are so wide-ranging that an arbitrary focus only is possible, or where the data wanted is not obtainable or available. As the CHR program fitted reasonably well with this description, the author elected to pay short visits of two to three days each to a number of reserves where CHR's were working. Though a longer time-period for observation or even participant observation would have been better, it was found necessary to rely heavily on memories and impressions of those who had been associated with the program for some time. Their observation about changes on the reserves over the period of time when the CHR's had been functioning, changes in services given or utilized, or alterations in the physical and social environment of each reserve, formed the background for placing the work of the CHR in perspective. As well, the Annual Reports of Medical Services in Alberta from 1965 to 1975 gave an idea of the services which had been offered by Medical Services over those years. Because of organizational shifts in administrative responsibility in Alberta and changes in methods of recording (sometimes reserves were recorded separately; sometimes they were grouped) it was not possible to use the statistical data to follow changes in such things as morbidity, mortality, or service patterns on any one reserve. Reports on the activities of the
health educators with regard to CHR's were included irregularly, and no separate mention was made of financial inputs to the program nor of the workers' activities themselves.

With the assistance of the health educator at Medical Services headquarters, seven reserves were selected for visits. Four criteria were used, to obtain as wide a range of CHR's and reserves as possible. These criteria were population size, distance from major population centres, the state of its economy and the evaluation of the resident CHR's work by field personnel. This last could introduce an element of bias into the author's observation, but since data was gathered mainly on the basis of the nurses' and CHR's impressions of their work, rather than on the author's personal observations, this was not considered to be extremely prejudicial.

On this basis, the reserves chosen were the Blood Reserve, Hobbema (Pigeon Lake Reserve), Hay Lakes Reserve, Wabasca-Desmarais, Morley, Lac La Biche and Kehewin Reserve. After sending a letter to the concerned as preparation, the author went to the reserve to observe the CHR in her work and to talk with her, and other Indian workers on the reserve, the Chief and the supervising nurses. An open-ended interview format was used in an attempt to reduce as far as possible the 'threat' posed by an outsider. The interviews attempted to cover all the basic areas of work mentioned by the objectives and the CHR's job description, as well as to solicit
feelings and impressions about the work situation, as these were also considered to have an effect on the program output.

The goals and objectives of the program, which formed the basis for the interviews, the data collection and the study as a whole are set out in Chapter IV, as a prelude to their analysis.
CHAPTER III

HEALTH AND SOCIAL STATUS OF INDIANS

A. HEALTH STATUS STATISTICS

"There are lies, damn lies, and statistics", Disraeli said - a still-valid commentary on the state of the art. In order to give the most accurate representation of the state of a phenomenon, statistics must be viewed in the context of how men, resources, policies and strategies of the recording agency cover a given community, assign resources and record happenings. They are not only a record of various phenomena, but are themselves an indication of the norms, values and goals of a society. Data are gathered only when phenomena are considered important and measurable and effective action can be taken on the basis of the information. They function to provide the basis of planning to future policies, though little is known systematically about the extent to which indicators are actually employed by policymakers. For many important policies there are no yardsticks by which to ascertain how things are changing in a society. Even if some statistics are chosen to indicate trends, they may give ambiguous measures of the magnitude and direction of change. For example, changes in definitions of a category such as mental illness can grossly alter the numbers which represent the phenomenon. Administrative procedures may cause startling changes e.g. hospital statistics in British Columbia at one time
recorded a zero incidence of alcoholism, for patients could not be admitted to an acute-care hospital with a diagnosis of alcoholism.

Statistics is a branch of mathematics which is concerned with the collection and analysis of quantitative data. Indian health and social status is measured in statistical series which are used for other Canadians and for many other countries in the world. This allows for a certain amount of comparability between groups in the society, and between countries. These statistics also fit into the concepts understood by policy-makers of health and illness and quality of life by which they carry out programs. In certain less clearly defined entities, such as mental illness, where cultural variance is influential, it is more difficult to be sure that like units are being counted together. The indicators used to measure the chosen entities usually reflect the orientations of the most powerful and articulate groups being affected by the phenomena being measured.

The index of health status at the demographic level is presently derived essentially from mortality data. Attempts to measure health using as the starting point the idea of wellness have foundered on the lack of criteria by which to measure this state of positive health. Thus, the three indicators of crude death rate, life expectancy and infant mortality are commonly
accepted as gross indicators of health, and provide reasonably accurate figures for comparisons within and between nations.  

More comprehensive measurements of health status, or what Suchman terms "social epidemiology", examine the social and psychological dimensions of health, as well as the scale of physical functioning e.g. measures of social disability, typologies of illness, perceptions of health care needs, motivations to utilize health services, and so on. This kind of information has been difficult to collect on a broad basis. Instead, score-keeping on certain diseases deemed to be more significant is carried out on a routine basis.

Because morbidity is less easily defined than death, statistics and jargon are less complex than for mortality data. Morbidity data are often based on "spells" of sickness, where each "spell" is counted, regardless of the patient's identity. Administrative definitions may also be used, such as admissions to hospital, or absence from school or work. Health surveys may record subjective impressions where a person reports feelings of disturbance in the state of his health, but these are not usually as important as other definitions of health status.

Morbidity data are collected from a variety of sources. Accurate information regarding incidence and prevalence of disease is obtained when its reporting is compulsory e.g. tuberculosis.
However this method does not give a comprehensive view of illness since it is restricted to a few diseases, not all cases are seen by a physician, and some cases seen may not be reported e.g. streptococcal sore throat. Hospital data are of high quality, but relate only to more serious conditions. Chronic diseases especially are under-reported since they may not seem serious enough to warrant a visit to a doctor. Thus the statistics are greatly affected by the population's willingness to utilize services and to comply with advice, as well as the physician's style of practice. Other sources of morbidity information such as physicians' private records, absentee records in schools and industry, or social insurance programs are also available. It is more difficult to extract information from these sources, and they are subject to certain inaccuracies. Special morbidity surveys can give comprehensive and detailed information on the population studies, but they are expensive and may not be comparable to other surveys, or may be too small to be generalizable.

Statistics collected by Medical Services Branch of the Department of National Health and Welfare are the main source of morbidity and mortality statistics presented here, supplemented by hospital statistics and the tuberculosis registries maintained by the provincial health departments. The count of disease and mortality in Indian communities is one of the main
inputs to Medical Services' planning and programming. Little systematic knowledge is available on the more sophisticated aspects of the measurement of health status as outlined above, though attempts are being made by Medical Services to collect information in Indian communities regarding such matters as housing, nutrition, sanitation, incidence of various types of illness and alcoholism, and other social and health problems.

Statistics published by Medical Services are based on populations figures issued by the Department of Indian Affairs and Northern Development as of December 31 of each year. Medical services accepts all births, deaths etc. reported for registered Indians in Alberta, though a considerable number live off the reserve and do not come under Medical Services' jurisdiction for health workers. They would be included under statistics for 'All Alberta'.

As Biderman points out \[^3\] (p. 97), we attempt to observe and comprehend aspects of reality which are important to us, but at the same time, "the aspects we are best able to observe and comprehend seem to be those that become important". Some evidence of this is seen in the statistics
which Medical Services compiles, and the programs it carries on, which seem to be mainly against the easily-counted problems.

**TABLE I. SELECTED VITAL STATISTICS**

**LIVE BIRTHS**

<table>
<thead>
<tr>
<th>Rate per 1000 population</th>
<th>1963</th>
<th>1973</th>
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<tbody>
<tr>
<td>All Canada</td>
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<td>15.5</td>
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<tr>
<td>Alberta Indians</td>
<td>52.3</td>
<td>38.8</td>
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<tr>
<td>All Alberta</td>
<td>27.4</td>
<td>17.4</td>
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**NATURAL INCREASE**

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<tr>
<td>All Canada</td>
<td>16.8</td>
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<tr>
<td>Alberta Indians</td>
<td>45.1</td>
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<tr>
<td>All Alberta</td>
<td>20.7</td>
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**INFANT DEATHS**

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<tr>
<td>All Canada</td>
<td>26.3</td>
<td>15.5</td>
</tr>
<tr>
<td>Alberta Indians</td>
<td>56.9</td>
<td>33.3</td>
</tr>
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<td>All Alberta</td>
<td>23.6</td>
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**CRUDE DEATH RATE**

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<td>7.4</td>
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<tr>
<td>Alberta Indians</td>
<td>7.2</td>
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</tr>
<tr>
<td>All Alberta</td>
<td>6.7</td>
<td>6.45</td>
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AVERAGE AGE AT DEATH

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<tr>
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<th>1973</th>
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<tbody>
<tr>
<td></td>
<td>Male</td>
<td>Female</td>
</tr>
<tr>
<td>All Canada</td>
<td>60.5</td>
<td>64.1</td>
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<tr>
<td>Alberta Indians</td>
<td>28</td>
<td>33</td>
</tr>
<tr>
<td>All Alberta</td>
<td>60.0</td>
<td>67.3</td>
</tr>
</tbody>
</table>


The rate of natural increase of Indians in Alberta of 3.1% in 1973 indicates the very high birth rates and the skewed age-structure of the native population—fifty-one per cent are under fifteen years of age, in comparison to the national figure of twenty-eight per cent. Over the past twenty-one years, Alberta has seen a 110.7% increase in its registered Indian population.

The high infant mortality rate is reflected in the lower average age of death. Of a total of twenty-five infant deaths in 1973 in Alberta, seven were due to infective and parasitic diseases (usually gastroenteritis), seven were due to respiratory disease,
six to suffocation (by bedding or regurgitation), and one to dehydration. The remaining four were related to the circulatory system, or were listed as "cause unknown". Most of the excess mortality in the Indian infant population occurs in the post-neonatal period and is said to be a result of pathophysiology, geographic isolation, difficulty of communication across cultural barriers, housing, sanitation, diet and parental apathy.

<table>
<thead>
<tr>
<th>TABLE II. LEADING CAUSES OF DEATH IN ALBERTA 1965</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alberta Indians</td>
</tr>
<tr>
<td>Symptoms, senility and ill-defined conditions</td>
</tr>
<tr>
<td>Diseases of the respiratory system</td>
</tr>
<tr>
<td>Accidents, poisonings and violence</td>
</tr>
<tr>
<td>Diseases of early infancy</td>
</tr>
</tbody>
</table>

\[N = 9,534\]

With 30% of the deaths being in the category of "symptoms, senility and ill-defined conditions", it is difficult to draw definite conclusions regarding the leading causes of death. Forty-three of the fifty deaths in this general category were due to "other, unknown and unspecified causes", and of the forty-three, fifteen were in people under twenty years of age. Medical Services expressed their concern to the Alberta Division of the Canadian Medical Association in that year, with apparently good results, as can be seen in the next table.

TABLE III. LEADING CAUSES OF DEATH IN ALBERTA 1973

<table>
<thead>
<tr>
<th>Alberta Indians</th>
<th>Province of Alberta</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accidents, poisonings and violence</td>
<td>Diseases of the circulatory system</td>
</tr>
<tr>
<td>37%</td>
<td>46.2%</td>
</tr>
<tr>
<td>Diseases of the circulatory system</td>
<td>Diseases of the respiratory system</td>
</tr>
<tr>
<td>17.5%</td>
<td>7.0%</td>
</tr>
<tr>
<td>Diseases of the respiratory system</td>
<td>Neoplasms</td>
</tr>
<tr>
<td>11.2%</td>
<td>18.6%</td>
</tr>
<tr>
<td>Infective and parasitic diseases</td>
<td>Accidents, poisonings and violence</td>
</tr>
<tr>
<td>5%</td>
<td>9.9%</td>
</tr>
<tr>
<td>Certain causes of perinatal mortality</td>
<td></td>
</tr>
<tr>
<td>5%</td>
<td></td>
</tr>
<tr>
<td>N=238</td>
<td>N=10,763</td>
</tr>
</tbody>
</table>

These statistics reflect partly the major revision of the International Classification of Disease of 1968, and partly a change in reporting of causes of death. In 1973 "symptoms, senility and ill-defined conditions" accounted for only 1.7% of Alberta Indian deaths. They must also be read in the context of the younger age-structure of Indian populations. Accidents, respiratory diseases, and infective and parasitic diseases heavily affect the young, while two of the leading causes of death in the province as a whole, cancer and cardiovascular diseases, are diseases of degeneration, affecting the elderly. Nevertheless, the fact of excess mortality for all age groups of the Indian population remains.

B. SIGNIFICANT ILLNESSES IN THE INDIAN POPULATION

Several aspects considered to be especially significant in the health profile of the Indian population have been selected for more detailed comment. These are the incidence of tuberculosis, communicable and nutritional disease, mental illnesses, accidents and violence, and alcohol abuse.

1. Tuberculosis

There has been a general decline in tuberculosis mortality in North America and Western Europe for the past one hundred years
but the reasons for this are not clear. The epidemiology of tuberculosis is of great interest for it appears to be heavily affected by cultural conflict. Ethnic, racial and economic minority status, industrialisation and urbanisation are all evident factors. Poverty, with the associated evils of malnutrition and poor housing, is usually involved. Alcoholism and mental illness are common problems in tuberculous patients. Life crises, such as changes in occupation or residence and marriage break-ups, are frequent in the two-year period before the onset of the disease. Thus tuberculosis can be considered a rough guide to a whole complex of variables existing in the environment and the individual which indicate low levels of health and living.

In the white population, the disease is more prevalent in elderly, debilitated, "socially marginal" people, and reactivations make up the majority of cases.

In marked contrast is the incidence of tuberculosis amongst Indians. In 1973 in Alberta Indians, the greatest incidence was in the age-group one to four years, and in 1972 in the group aged five to nine. Even though the percentage of the Indian population in these age-groups is greater than in
the white population, the incidence of cases here is far out of proportion to the numbers of children. About ninety per cent of the cases were new cases, not reactivations. Intensive contact with persons with an active case of the disease is the main reason for the high incidence in children, aided by overcrowded poor housing, poor diet, ignorance of the implications of symptoms and process of the disease, fear of being removed to a far-distant hospital and so on.

The following table will give an indication of the differences between Indian and white populations. The statistics are not strictly comparable, since Medical Services reports morbidity rates per 100,000 population (new and reactivated cases found that year) while provincial statistics are reported as "patients undertreatment" i.e. cases discovered that year, plus patients still being treated from previous years. The figures are complicated slightly by non-Alberta treaty Indians living in Alberta being included and Alberta treaty Indians living outside the province not being represented. The numbers are small and do not alter significantly the over-all picture. The Indian rate per 100,000 is based on the population of all Alberta bands.
TABLE IV.  TUBERCULOSIS RATES IN ALBERTA

<table>
<thead>
<tr>
<th>Year</th>
<th>Province of Alberta</th>
<th>Alberta Indians</th>
</tr>
</thead>
<tbody>
<tr>
<td>1963</td>
<td>339 being treated</td>
<td>208 discovered</td>
</tr>
<tr>
<td>1973</td>
<td>311 being treated</td>
<td>75 discovered</td>
</tr>
</tbody>
</table>

Rate of reported cases per 100,000 population

- 1963 Province of Alberta: 24.1
- 1963 Alberta Indians: 280.0
- 1973 Province of Alberta: 18.6
- 1973 Alberta Indians: 244.4


2. Other Communicable Diseases

The amount of communicable disease is another indicator of the health of a population, and indirectly of its social status, for most communicable diseases are more prevalent in areas where people have inadequate housing, water supplies, diet and education. The following table compares case counts and ratios for several important diseases. The ratio of the registered Indian population to the provincial population is 1:53, the Indians making up about 1.9% of the provincial population.
TABLE V  COMMUNICABLE DISEASE CASES AND RATIOS  1973  Alberta

<table>
<thead>
<tr>
<th>Disease</th>
<th>No. of cases in Indian population</th>
<th>No. of cases in province</th>
<th>Ratio of cases Indians:province</th>
</tr>
</thead>
<tbody>
<tr>
<td>Typhoid</td>
<td>1</td>
<td>3</td>
<td>1:3</td>
</tr>
<tr>
<td>Salmonella</td>
<td>42</td>
<td>545</td>
<td>1:13</td>
</tr>
<tr>
<td>Bacillary dysentery</td>
<td>40</td>
<td>322</td>
<td>1:18</td>
</tr>
<tr>
<td>Diphtheria</td>
<td>19</td>
<td>89</td>
<td>1:4.7</td>
</tr>
<tr>
<td>Strep throat</td>
<td>16</td>
<td>3624</td>
<td>1:227</td>
</tr>
<tr>
<td>Infectious hepatitis</td>
<td>15</td>
<td>1321</td>
<td>1:88</td>
</tr>
<tr>
<td>Measles</td>
<td>33</td>
<td>561</td>
<td>1:17</td>
</tr>
<tr>
<td>Whooping cough</td>
<td>1</td>
<td>34</td>
<td>1:34</td>
</tr>
</tbody>
</table>


The Indians are generally over-represented in all the categories except for streptococcal sore throat and infectious hepatitis. Infectious hepatitis is a disease which often has vague, ill-defined symptoms which might not, in the mind of a person unaware of their significance, justify a trip to a health professional, especially if the trip involved considerable time, trouble and expense. Likewise for strep throat, which can easily be taken for "ordinary" sore throat and not deemed to be serious.

Other infectious diseases are highly prevalent, though
not serious enough to warrant inclusion in published statistics. The Annual Report of Medical Services in Alberta in 1972 noted that

The major health problems of the Indian people include infestations with scabies and lice, tooth decay, otitis media, tuberculosis and other infectious diseases.⑥ (p.15)

3. Nutrition

Nutritional status of persons has been found to be associated with reproductive capacity and prenatal and infant survival, physical growth and development, and rates and effects of infections.⑦ Socioeconomic data and food consumption patterns show that the average Indian family’s diet is now marginally adequate. The Indian diet before contact with white men’s thought to have been generally nutritious.

The high infant mortality and childhood morbidity rates of Indians and their generally smaller size and weight suggest suboptimal nutritional states. Severe malnutrition is not usually seen on reserves, except in association with child neglect. The nutrition survey carried out in Canada by the Dept. of National Health and Welfare in 1973 indicated a high prevalence of nutritional problems among natives, such as low intakes of many of the vitamins and minerals in all age groups, including pregnant women, and too low caloric
intakes among adolescents, the elderly, and middle-aged women, in spite of the high incidence of obesity in the latter group—results considerably poorer than for the general population. 8

4. Mental Illness

The 1968 Annual Report of Medical Services in Alberta was the last one containing statistics on mental illness among Indians. Details of the number of patients in mental institutions, and estimates of the number of mental defectives and mentally ill persons at home were carried, but since then, no mention is made of this category in the annual reports.

Mental illness is a difficult phenomenon to quantify, and some authors such as Thomas Szasz claim that mental illness is largely a "myth", a concept analogous to that of witchcraft, justifying an oppressive method of social control. Leighton and Murphy say that psychiatric disorders are patterns of behaviour and feeling which are out of keeping with cultural expectations and which bother the person who acts and feels them, or bother others around him, or both (p. 189). 9

Different cultures, by definition, have different standards and expectations, and what may be disturbing in one is not necessarily so in another. However, these authors feel that both culture and personality are not infinitely plastic and variable, but share some
common ground, so that the symptoms of mental illness are recognized as such in most cultures, though are ascribed different diagnostic categories and theories of causation.

Indians would likely be under-represented in studies of mental illness based on figures of patients under the care of psychiatrists or in mental institutions. A series of recent studies have established a significant relationship between social class and prevalence of treated psychiatric disorders. As Medical Services had no figures on numbers of Indians receiving psychiatric care in Alberta other indicators of mental stress for which there are figures, have been chosen to give a rough idea of the prevalence of mental problems.

5. Accidents, Violence and Suicide

In 1965, there were twenty-four Indian deaths due to "accidents, poisonings, and violence", compared to seventy-one in 1973 -- a 300% increase. The Indian population had grown by only 34 per cent in these years. Accidental deaths are the leading cause of death in 1973 for all age groups between thirteen months and forty-nine years. In 1969, all of the male deaths (17) in the twenty to twenty-nine year age-group were caused by accident or violence, with alcoholic intoxication a known contributory factor
This high rate of accidental death could be due mainly to the dangers of the environment in which many Indians live e.g. the old, unsafe cars many drive, the wood frame houses with faulty heating systems or open fireplaces, the prevalence of guns where people hunt and trap for a living.

Karl Menninger adds a further consideration.

We know that suicide can be accomplished indirectly, that is, without the active, conscious participation of the individual. We know of people who seem to have accidental deaths, which, we are convinced from our knowledge of the case, are unconsciously determined. (they have) unconsciously wished for it. \(^{12}\) (p. 347)

The theory fits with the high rate of known suicide and self-inflicted injury which accounted for approximately fourteen per cent of Alberta deaths in 1972 among Indians, compared to a national rate of 5.1/100,000 among males and a rate of 1.6/100,000 among females in 1972.

6. **Alcohol Abuse**

As one man said, "It's the only time I feel like a man -- when I'm drunk."\(^{13}\)
A combination of psychological need for relief from various stresses and the social pressure and support from a similarly-thinking subgroup seems to create a self-reinforcing process entrapping many Indians.

The effects of alcohol are devastating and reach into every aspect of Indian life. The association of alcohol with crime, homicide, accident, unemployment and divorce is well documented in the white population and Indians are subject to the same effects. A study of sudden deaths in British Columbia in 1969 showed that a high proportion of them occurred in Indians who had been drinking. The death rate from suicide was almost three times greater for Indians than for non-Indians; the accidental death rate almost four times greater, and the death rate from homicide over thirty times greater. Alcohol was a known factor in over seventy per cent of the cases. A doctor with long experience with Indian patients stated that the incidence of infant morbidity and mortality due to malnutrition, exposure, burns, pneumonia, skin infections and chronic ear infections is strikingly higher in families where a great deal of drinking is carried on. Excessive drinking contributes to reserves often being split into two factions: the drinkers and the non-drinkers. Whatever the dynamics of drinking among Indians, alcohol contributes to a very large percentage of the socio-medical and mental health problems of Indian communities. In fact, its unfortunate presence can be seen in the background of every statistic quoted in this chapter.
C. SOCIAL STATUS OF INDIANS

1. Difficulties of Measurement

Social indicators serve as indices of socially important conditions in society. However, a key problem is the definition of "social". Roughly, social indicators could be described as the non-economic aspects of a society e.g. education, health, housing and crime and other less obvious aspects: political participation, social mobility, status of minorities, morale etc. They try to measure well-being, or the 'quality of life' in a society, and are closely related to the objectives of a society, especially those articulated as national policy.

They suffer from important deficiencies though. Even if a society agrees on the various goals it wishes to achieve, it is difficult to match these goal statements with acceptable indicators of achievement of these goals. Often the means used to attain goals are more easily quantifiable than the goals themselves and there is a danger of viewing these means as ends-in-themselves. Especially for social, noneconomic factors such as political and economic organization, psychological attitudes and human resources, quantitative measurement is lacking to a more serious extent than for other variables. Thus the objectivity of such data is less, since objectivity depends on the character of the symbols used to describe the phenomena, and the meaning of numbers between people
is more similar than is the meaning of words. These factors are measured only indirectly; surrogates that stand in the place of the variables of interest are measured. For example, it is not possible to measure "egalitarian sentiments" in a society, but it is possible to compile statistics about the distribution of wealth.

One tactic used to get around measuring difficulties is that of concept reduction i.e. the social concept is defined as that which is measured by the operational definition, which may differ considerably from the otherwise-established content of the concept. Much social indicator data are indirect, having been collected for other purposes, and this makes it difficult to combine with other data to construct an index, or multi-definitional indicator of social status.

The accuracy and validity of the data which is collected depends on the competence of the data-gathering agency, the openness of the subject to investigation and the susceptibility of the subject to measurement. There is a tendency to ask questions which are more easily quantified and questions of quality may be downplayed. Other influences affecting what data are gathered are not entirely rational in terms of information actually needed: availability of resources, political issues which push certain issues to the fore and downplay others, relative strengths of important officials in statistics-producing agencies and so on.
2. **Social Indicators**

It has been suggested that a reasonably full description of social status should include the measurement of incomes - their levels, stability and source (the latter affecting the social 'honor' of individuals) and various measures of comparative income such as share of the national income. Assets should also be measured - housing, durable goods, savings, insurance. Basic services are important, such as education, training, health, protection and transportation. A person's political position, his integration into the political process, and the sensitivity of representatives to certain groups, along with his social mobility and feelings of satisfaction as to his life would help to round out the measurement of social status. Indicators, in the eyes of the National Commission of Technology, Automation and Economic Progress in the United States, should also include the measurement of social costs and net returns to economic innovations, the measurement of social ills e.g. crime, family disruption, and the measurement of economic opportunity.

Obviously, desirable as all this information would be, it is not available in a systematic numerical form for Indians or the population as a whole. Such indicators as average income, employment patterns, dependence on welfare, educational levels achieved, housing and certain facilities are quantified, and are useful to give a rough idea of the social status of Indians.
A major focus for describing the place of Indians in Canada today seems to be not in terms of racial or cultural differences, their separate political identity, geographic distribution, their numbers or many other facets of their existence. They are described in terms of poverty. It is a term which seems to cast a very wide net, including in it incomes, houses, jobs, education, community services, goals, attitudes, adaptive behaviours and so on. "Poverty" is a societal definition, and "lower-class" and "poor" lump together people who may be very heterogeneous in their backgrounds, problems and coping behaviour.

The Economic Council of Canada defines poverty not as a sheer lack of essentials to sustain life, but as lack of access to certain goods, services and conditions of life which are available to everyone else and which have come to be accepted as basic to a decent minimum standard of living. It is not only economic insufficiency, but social and political exclusion as well. Poverty is relative. In terms of the poverty line set by the Council, where $3,500 was needed in 1961 to sustain a four-person family, three-quarters of Indians earned less than $3,000 per year, and supported larger families than four.22
### TABLE VI. INCOME POSITION OF INDIANS IN CANADA

<table>
<thead>
<tr>
<th>Year</th>
<th>Per capita yearly income</th>
<th>Indians</th>
<th>Canada</th>
</tr>
</thead>
<tbody>
<tr>
<td>1964</td>
<td>$300</td>
<td>$1,400</td>
<td></td>
</tr>
<tr>
<td>1973</td>
<td>$500</td>
<td>$5,513 (approx.)</td>
<td></td>
</tr>
</tbody>
</table>


The difference, as Hawthorn explains\(^{23}\) is due to the Indian's concentration in low-paid industries, the wide prevalence of unemployment and the lower percentage of the population being in the productive age-levels of 16-64 years--45% as compared to the Canadian average of 65%. Only 11.5% of Indian reservation households had incomes of $4000 or more in 1965 (compare this to the poverty line quoted above) and 78.5% received less than $3,000. This takes into account the income derived from farming, trapping and fishing, arbitrarily set at $50 monthly.\(^{24}\) The national average unemployment for employable Indians ie. not disabled, is 56%, compared to an overall national average varying between 6 and 10%.\(^{25}\) It should be noted that Indians pay no income tax on earnings made on the reserves.
The number of employable Indian adults receiving public welfare was about ten times the national average in 1969. \(^2\) A survey conducted in 1966-68 in Alberta Census Division 15, covering fifteen reserves in northern Alberta, found the same syndrome of low incomes and high dependence on welfare.

<table>
<thead>
<tr>
<th>TABLE VIII</th>
<th>REVENUES OF THE FIFTEEN INDIAN BANDS IN C. D. 15 1966-1967</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population</td>
<td>5,511</td>
</tr>
<tr>
<td>Leases</td>
<td>$10,438</td>
</tr>
<tr>
<td>Ranching</td>
<td>34,500</td>
</tr>
<tr>
<td>Oil and Gas</td>
<td>258,498</td>
</tr>
<tr>
<td>Fishing</td>
<td>23,500</td>
</tr>
<tr>
<td>Welfare</td>
<td>372,408</td>
</tr>
<tr>
<td>Total</td>
<td>$957,102</td>
</tr>
</tbody>
</table>

Per capita income $173.67


Average annual welfare payment per household in 1968 was $579. No information was available on off-reserve earnings, which would raise the average per capita income somewhat. Welfare payments account for about one-third of revenues of the fifteen bands, similar to Hawthorn's survey.
ii) Housing

The same study examined housing on the fifteen reserves. Considering that the average family size was six, a six-room house having three bedrooms, a kitchen, sitting room and bathroom would be adequate. Under these criteria, only thirty-two of the 688 homes or 4.6% were adequate; about 75% were three rooms or less\(^2\) (p. 308).

| TABLE VIII SERVICES IN INDIAN HOMES CENSUS DIVISION 15, 1968 |
|-----------------|-----------------|-----------------|-----------------|-----------------|
|                 | Electricity    | Flush Toilet   | Running Water  | Telephone       |
| C. D. 15        | 53.3%          | 2.8%           | 4.2%           | 1.6%            |
| Canada, 1971    | 98%            | 93.1%          | 96.1%          | 95.0%           |


Many remote communities in the north of Alberta are without any dependable form of electronic communication, even for emergency use.\(^2\)

iii) Education

The relationship between the economic development of a country with the educational levels achieved therein shows a higher degree of correlation than for any other variable, according to the UN Report on the World Social Situation.\(^2\) Although Hawthorn found important exceptions to this among the bands he surveyed, he felt that the correlation generally held.
For those desiring integration into the mainstream of
Canadian society, education in its institutionalized white middle-
class definition is deemed crucial. Integration, in contrast to
assimilation, encourages the newcomer to a society to retain what
he regards as best in his cultural background, to contribute to
the richness of society. It implies full equality in services
and opportunity. Assimilation on the other hand denotes the loss
of cultural identity. For some Indians, the educational system
is seen as an organized and continuous method of processing
Indians into dark-skinned white men, a process of cultural
extermination. The dilemma of reconciling an "Indian identity"
with full participation in the educational system and the job
market is a real one. Often, getting a higher education means
removal from the home community for prolonged periods. Once a
person is educated, there are few job opportunities for him in
these communities. The prospect may well appear to a young
Indian as a "non-choice" between being excluded from his home
community, yet not ever fitting into the white man's society
either.

The position of the Indians in regards to educational
levels is revealed by statistics on numbers attending schools
and post-secondary institutions.
TABLE IX  GRADE DISTRIBUTION OF INDIAN AND OTHER PUPILS IN ALBERTA SCHOOLS

<table>
<thead>
<tr>
<th></th>
<th>Pupils in Indian Schools</th>
<th>Indian Pupils in Other Schools</th>
<th>Total Indian Pupils</th>
</tr>
</thead>
<tbody>
<tr>
<td>1966-67</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Elementary</td>
<td>83.6%</td>
<td>65.5%</td>
<td>72.4%</td>
</tr>
<tr>
<td>Junior High</td>
<td>15.4%</td>
<td>26.5%</td>
<td>21.4%</td>
</tr>
<tr>
<td>Senior High</td>
<td>1.0%</td>
<td>8.0%</td>
<td>6.2%</td>
</tr>
</tbody>
</table>


Nationally, 50% of Indian students do not go beyond Grade Six and 97% fail to reach Grade Twelve. 30

About 300 Indians were enrolled in post-secondary institutions in Alberta in 1973, only thirty-six receiving apprenticeship training in skilled trades. This represents .5% of all Albertans registered in apprenticeship programs. 31

What emerges is that the present educational levels of most natives are far below those of most other Canadians, and the gap has not been narrowing appreciably over the years since World War II, when the national government decided that education was as necessary for Indians as for other Canadians.
All these figures show one side of the communities in which the Community Health Representatives live and work. They problems they and Medical Services personnel face are not just those of various physical diseases, but the background from which they arise—unemployment, poor education and housing, low incomes. As well, the material and technological aspects of Indian life are accompanied by a non-material culture—the values, beliefs, modes of behaviour which affect the health of the community; the health services must also come to grips with these if health programs are to be effective.

iv) Social Deviance

Information collected on social "acts" reveals as much about the culture gathering the information as about those people on whom information is collected. Especially in the areas defined as "deviant behaviour", the way people come to be labelled as suspects or victims, deviant or desirable, is culturally determined. Official statistics are relevant, but it must be realized that the units in a given rate of behaviour can be the result of quite different behaviours i.e. the "objective" manifestation of the same form of behaviour can lead some individuals to be classified as deviant, but not others. For example, the criteria used to identify a person as a "vandal" or as "incorrigible" are very vague and include wide ranges of behaviour.
The following statistics show aspects of reserve life which have been quantified and which are both a result of and a cause of the health and social problems on reserves.

### TABLE X

<table>
<thead>
<tr>
<th>Fiscal Year</th>
<th>Number of Children in Care, March 31</th>
<th>Total Costs</th>
<th>% Increase Over Previous Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>1963-64</td>
<td>3360</td>
<td>$1,732,945</td>
<td>23.0</td>
</tr>
<tr>
<td>1964-65</td>
<td>3642</td>
<td>2,083,000</td>
<td>24.5</td>
</tr>
<tr>
<td>1965-66</td>
<td>3199</td>
<td>3,464,000</td>
<td>18.9</td>
</tr>
<tr>
<td>1966-67</td>
<td>3637</td>
<td>3,511,000</td>
<td>20.2</td>
</tr>
<tr>
<td>1967-68</td>
<td>4311</td>
<td>4,851,000</td>
<td>53.8</td>
</tr>
<tr>
<td>1968-69</td>
<td>4541</td>
<td>6,834,974</td>
<td>44.0</td>
</tr>
<tr>
<td>1969-70</td>
<td>5062</td>
<td>8,097,995</td>
<td>18.5</td>
</tr>
<tr>
<td>1970-71</td>
<td>5395</td>
<td>11,679,339</td>
<td>44.2</td>
</tr>
</tbody>
</table>

The Department of Health and Social Development in Alberta in 1973 had 24% of its child care cases coming from less than 2% of the population (i.e. the Indian population), mostly as a result of abandonment by parents who had problems with alcohol.\(^{32}\)}
Illegitimacy is commonly used as a measure of personal or social disorganization. This is changing now, especially in middle-class society, where deliberate choices are being made to have children outside of legal marriages, and the social stigma of so doing is lessening. It must be noted also that the illegitimate offspring of the union of a treaty Indian mother and a non-treaty father are considered treaty Indians and receive the benefits specified under the treaties, whereas the legitimate children do not. To classify illegitimacy as deviance, it must be assumed that a norm of legitimacy exists among Indians. A study of a reserve in Quebec carried out in 1964 supported the hypothesis that commitment to the norm of legitimacy existed, but was weak due to a lack of social and cultural integration both within the community and between the community and the nation. This led to low commitment to both aboriginal and European norms and lack of social control of deviants.33

**TABLE XI: PER CENT OF ILLEGITIMATE BIRTHS - OF TOTAL LIVE BIRTHS**

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1967</td>
<td>16.9</td>
</tr>
<tr>
<td>Province of Alberta</td>
<td>1966</td>
<td>11.8</td>
</tr>
<tr>
<td>Canada</td>
<td>1966-70</td>
<td>8.7</td>
</tr>
</tbody>
</table>


*Illegitimacy refers to those births in which the parents reported themselves as not having been married at the time of birth or registration.*
Jail statistics show an undue proportion of native people incarcerated. In Alberta, where the native population (i.e. registered Indians and Metis) is 5% of the provincial population, the 1972 Annual Report for the Corrections Branch of the Alberta Attorney-General's Department shows the following percentages of Indian and Metis prisoners:

<table>
<thead>
<tr>
<th>Institution</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lethbridge Correctional Institute</td>
<td>61%</td>
</tr>
<tr>
<td>Fort Saskatchewan (males)</td>
<td>25%</td>
</tr>
<tr>
<td>Fort Saskatchewan (females)</td>
<td>62%</td>
</tr>
<tr>
<td>Nordeg Correctional Institute</td>
<td>60%</td>
</tr>
<tr>
<td>Calgary</td>
<td>12.7%</td>
</tr>
<tr>
<td>Peace River</td>
<td>54%</td>
</tr>
</tbody>
</table>

The high arrest rates may be partially a result of social attitudes and legal discrimination towards natives, but the significance of the crimes can be given a proper perspective only when the type of crime is examined: the number of liquor infractions and alcohol-related crimes in every region of Canada is so great as to almost exclude all other kinds of Indian crime.

The rates of alcoholism, mental illness, accidents and violence quoted above must be very disruptive to family and community life. By their very existence, they put more stress on the Indian people, requiring further adaptive efforts on their part, and thus tend to assure the continuance of the pathology.
These health and social status statistics are but meagre quantifiers of the state of the Indian communities in Alberta. Their exact interrelationships are not known, but they were chosen on the assumption that they are all important: the less educated tend to be poor, the poor tend to be sicker, and the sick are less able to do anything about their poverty. Other factors, not so easily quantifiable, enter into the determination of health levels of people as well, and will be detailed further on. It was the evidence of these figures supplemented by knowledge of mostly unquantified social, political and psychological variables which formed the background of the Community Health Representative Program, and make up the context in which it now operates.
CHAPTER IV

OBJECTIVES OF THE CHR PROGRAM

A. WRITTEN OBJECTIVES

The over-all objectives which were written at the program's inception are intended to give only a broad guide to the direction of the program, and are not measureable as they stand. The author turned to the CHR job functions (see Appendix 3, Job Description for CHR's) related to the first two objectives from these derived immediate, short-term and intermediate objectives, each intended to incrementally increase the chance of reaching the program objectives and the ultimate goal of Medical Services.

The official program objectives are set out below with the job functions related to each. The immediate objectives derived by the author proved to be operational and could be measured if data were compiled regularly. They formed the basis for the interviews and examination.
**Program Objectives:**

A. To encourage the participation of local people in the health activities of their communities, by involving them in the initiating, planning and carrying out of programs.

**Job Function:**

Provides consultation, advice and assistance to individuals and families on health matters and makes appropriate referrals when necessary by making home visits to prenatales, mothers with infants and young children, 45% of the time.

<table>
<thead>
<tr>
<th>Immediate Objectives</th>
<th>Intermediate Objectives</th>
<th>Long-term Objectives</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. to have all pregnant women attend prenatal clinic</td>
<td>1a. to detect high-risk pregnancies</td>
<td>1a. to have all pregnant women delivered safely of healthy children as far as is possible with modern technology</td>
</tr>
<tr>
<td></td>
<td>1b. to give good prenatal care</td>
<td>1b. to reduce perinatal mortality to acceptable levels</td>
</tr>
<tr>
<td>2. to have all children immunized completely</td>
<td>2. to raise the level of immunity</td>
<td>2. to reduce the amount of communicable disease in the community</td>
</tr>
<tr>
<td>3. to teach people the elements of a nutritious, economical diet</td>
<td>3. to improve people's eating habits</td>
<td>3a. to reduce the amount of obesity, hypertension and diet-related disease</td>
</tr>
<tr>
<td>4. to teach people good dental hygiene</td>
<td>4. to increase the use of toothbrushes and dental services</td>
<td>3b. to raise people's resistance to disease to the highest possible levels</td>
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<tr>
<td></td>
<td></td>
<td>3c. to provide optimal conditions for children's growth and development</td>
</tr>
<tr>
<td></td>
<td></td>
<td>4. to reduce dental pathology and related diseases</td>
</tr>
<tr>
<td>Immediate Objectives</td>
<td>Intermediate Objectives</td>
<td>Long-term Objectives</td>
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<tr>
<td>5. to teach the community and parents aspects of a safe and hygienic environment</td>
<td>5a. to remove domestic and environmental hazards</td>
<td>5a. to reduce the incidence of accidents of all types and the resultant disability and death</td>
</tr>
<tr>
<td>6. to teach people the value and techniques of family planning</td>
<td>5b. to improve the level of personal and domestic hygiene</td>
<td>5b. to reduce the incidence of disease related to poor hygiene</td>
</tr>
<tr>
<td>7. to teach people the necessity for adequate exercise</td>
<td>6a. to allow people to space their children adequately</td>
<td>6a. to help ensure children are welcome and adequately cared for</td>
</tr>
<tr>
<td></td>
<td>6b. to reduce the incidence of illegitimacy</td>
<td>6b. to reduce perinatal morbidity and mortality</td>
</tr>
<tr>
<td>8. to make people aware of the dangers of alcohol abuse</td>
<td>7a. to help people obtain recreational and exercise facilities</td>
<td>7a. to provide an alternative to health-destroying behaviours</td>
</tr>
<tr>
<td></td>
<td>7b. to increase the amount of exercise taken by those needing it</td>
<td>7b. to reduce the amount of disease related to lack of exercise eg. obesity, heart disease</td>
</tr>
<tr>
<td></td>
<td>8a. to reduce the amount of drinking and alcohol abuse</td>
<td>8a. to reduce the amount of alcohol-related disease, accidents and deaths</td>
</tr>
<tr>
<td></td>
<td>8b. to provide alternative activities to drinking</td>
<td>8b. to provide alternative activities to drinking</td>
</tr>
<tr>
<td></td>
<td>8c. to help people control their own and others' drinking</td>
<td>8c. to help people control their own and others' drinking</td>
</tr>
</tbody>
</table>
9. to give elementary home nursing care to the elderly, sick or infirm and/or to teach others to do so.

9a. to maintain the health of people at current levels or to improve it.

9b. to reduce the extent of institutionalization for health care

9c. to help families support each other

9d. to reduce family break-up

9e. to provide cheap & appropriate care

10. to help arrange for transportation, babysitting or other forms of support

10a. to enable people to use resources & services

10b. to increase the appropriate utilization of resources and services

10c. to ameliorate some of the people's problems within the scope of services available

11. to perform basic screening and physical examinations

11a. to detect abnormalities needing further care

11b. to provide a basic data base on people

11c. to see that people receive further necessary care

11d. to facilitate the planning of programs & services

12. to take and record water samples for analysis

12a. to advise people of the need to purify their water

12b. to advise local authorities of any need for safe water supplies
Program Objective: as before

Job Function: Assists the community and groups within the community to improve their health status 40% of the time.

13. to teach health classes in federal schools at least once a month

13a. to arouse interest among teachers and students in health matters

13b. to give teachers and children an understanding of some of the elements of healthful living

13c. to help inculcate habits of healthful living at a young age (in the children's case)

13d. to prevent or to reduce disability and morbidity

13e. to help change unhealthful ways of living to more beneficial ones

14. to develop and posters and displays, use films, slides etc. in health education programs

14a. to arouse interest among the community & inform them about health matters & services

14b. to reinforce retention of information & understanding of health matters by using a variety of media

14c. to present information in a way which is more understandable & acceptable to local people

15. to utilize available mass media to disseminate health information

15a. to reach a wide number of people with health information

15b. to complement & supplement other modes of teaching public about health

15c. to help people change unhealthful ways of living to more beneficial ones
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<table>
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<tbody>
<tr>
<td><strong>16.</strong> to regularly attend Band and Council meetings</td>
<td><strong>16a.</strong> to keep health workers informed about local current situations of importance to their work</td>
</tr>
<tr>
<td></td>
<td><strong>16b.</strong> to interest local Indian administrators in health matters</td>
</tr>
<tr>
<td></td>
<td><strong>16c.</strong> to allow workers to give advice when asked for, and recommend needed local improvements</td>
</tr>
<tr>
<td><strong>16a.</strong> to create Indian leaders who are well-informed about and able to administrate health programs</td>
<td></td>
</tr>
<tr>
<td><strong>16b.</strong> to arouse appropriate local demand for services and programs</td>
<td></td>
</tr>
<tr>
<td><strong>17a.</strong> to increase resources in the community available to health workers</td>
<td></td>
</tr>
<tr>
<td><strong>17b.</strong> to arouse widespread interest in and knowledge about health matters</td>
<td></td>
</tr>
<tr>
<td><strong>17c.</strong> to support existing attempts to meet problems in the community</td>
<td></td>
</tr>
<tr>
<td><strong>17d.</strong> to create a well-informed group who are able to administer health and other programs</td>
<td></td>
</tr>
<tr>
<td><strong>17a.</strong> to improve the chances of acceptance and success of health programs</td>
<td></td>
</tr>
<tr>
<td><strong>17b.</strong> to meet demands and needs which the community defines as important</td>
<td></td>
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</tbody>
</table>
18. to take an active role on health committees eg. draw up budgets, secure funding, supervise garbage collectors and water-suppliers, etc.

18a. to assist groups to be successful in their chosen tasks

18b. to widen the scope of local committees

19. to organize, plan, secure funds for and conduct workshops, short courses, continuing health education programs, youth summer camps, etc.

19a. to engender beliefs and attitudes conducive to greater active control of themselves and their environment

19b. to reduce problems created by lack of employment and recreation facilities

20. to work with community leaders and workers, and with government officials to resolve problems affecting the health of a community (This could also be placed with the Program Objective following)

20a. to foster interest in and habits of cooperation between workers

20b. to achieve the greatest possible return to input by combining resources

18. to improve skills in leadership and administration in local people
Program Objectives: B. To give professional health workers an opportunity to become more effective by providing a link with the local community.

Job Functions: As before

21. to interpret between non-bilingual care-givers and consumers

21a. to enable care-givers to understand clients' problems and provide appropriate care

21b. to encourage and enable clients to use services

21c. to help local people understand the ways of a bureaucracy and white professionals

22. to advise health care personnel on the local culture, values, traditions, politics, etc.

22a. to help health care personnel understand the people's behaviour

22b. to help personnel change people's behaviour beneficially

22c. to allow personnel to adapt their services to local customs and needs

22d. to increase the satisfaction for personnel of working with Indians

22e. to help make health personnel aware of their personal beliefs, biases, and feelings about Indian people

21a. to help ensure safe and appropriate care is given when needed

22a. to avoid destruction of beneficial habits

22b. to replace unhealthy habits with healthy ones

22c. to make services more acceptable to people and thus more likely to be used

22d. to decrease turnover among personnel
23. to advise people of and assist them to use the resources and services available to them eg. nurses, RCMP, Dept. of Indian Affairs and Northern Development

24. to make health care personnel aware of their personal beliefs, biases and feelings about Indian people

23. to increase the use of available services appropriately

23. to reduce the incidence and severity of problems within the scope of the services

24. to allow personnel to deliver a service which is as sympathetic as possible to the needs of the client
B. GENERAL ANALYSIS OF OBJECTIVES

The goal of the Indian Health Services Branch of Medical Services (hereafter referred to as Medical Services) is to help the Indian and Eskimo population of Canada to attain the standards of health and living conditions which are comparable to the rest of the population.

It is a statement of the general purpose of Medical Services and as such, is quite vague and ambiguous, providing an idea as to the primary direction for all activities of the Service, and at the same time allowing for the maneuverability necessary to functioning under changing conditions. For example, the inclusion of "living conditions" in this goal suggests a very wide field of activity is possible for Medical Services, implying involvement in activities which might be more rigorously defined as belonging to economic, political or social spheres. The phrase "comparable to the rest of the population" also allows for wide interpretation. Comparability does not mean equality, but implies a not-too-great disparity between Indians and other Canadians. Since Indians are mainly rural, it might more realistically refer to rural Canadians, rather than to the whole rest of the population, rural and urban.

One of the means to this over-all goal is the training and employment of Indians as Community Health Representatives. When the program was initiated, three shorter-term goals were
set out for it. These objectives, or fundamental strategies, as Drucker uses the term, must be viewed within this framework of the existence of a "health gap" i.e. deficiencies in the health status and health care of Indians in comparison to most Canadians. The program could also be viewed as a part of a package of programs with broader social objectives, such as the alleviation of poverty or the improvement of education. In fact, in a number of monographs and papers on the program, the main initiator of the program mentioned community development as the wider context within which the workers were to pursue the goal of improved health. They were to be "observers, diagnosticians, strategists and stimulators" in helping to promote growth and development leading to improved health in their communities. However, since that purpose is not mentioned directly in the official program objectives, nor did it seem strongly evident in the activities being carried on in the name of the program, the evaluation is approached from the viewpoint of the health status of the native people, i.e. are the objectives appropriate to health needs and the resources available. It would be interesting to examine the legitimacy of the goal of community development in the overall context of government dealings with Indians, and to speculate on some of the

*See also E. Martens "Training Auxiliary Health Workers in Community Development", paper prepared for Community Development Seminar, by the Department of Health Education, School of Public Health, University of North Carolina, Chapel Hill, May 5-9, 1963.
factors which led to the seeming disappearance of this goal, but this is beyond the scope of this study.

The analysis of program objectives cannot stop at the level of the official objectives. These reflect values which the administration believes will be accepted as legitimate, but they do not indicate priorities among the several objectives, nor do they indicate all the objectives being pursued by the members of an organization. These "operative" or unofficial goals can be inferred from observing the actual activities and operating policies of an organization. They are implicit in the way things are done, rather than explicitly recognized.  

Another important feature to note is that specific targets and assignments can be derived from objectives which are operational i.e. objectives should give some indication of possible courses of action, and whether and to what extent an objective will be realized by a sequence of actions. They must be clear, formulated in concrete terms and understood by all employees. Another necessity is that objectives be realistic. There must be a reasonable congruity between the capabilities of the organization and the objectives to be reached - sufficiently challenging to be motivating but not so frustrating as to be demoralizing. The last factor is that objectives should be in a logical hierarchy with shorter-term subordinate objectives contributing no longer-term and higher-level ones.
The objectives of the program will be outlined and discussed according to the criteria given above for "ideal" objectives, both the official objectives, and those inferred by the author from the job description of the Community Health Representative in Alberta as laid out by Medical Services. The assumption being made, of course, is that the job functions determined for these workers are considered by Medical Services to be techniques of reaching subordinate goals, which are a means to the higher-level official program objectives.

The three official objectives set out for the program are:

A. To encourage the participation of local people in the health activities of their communities by involving them in the initiating, planning and carrying out of programs.

B. To give professional health workers an opportunity to become more effective by providing a link with the local community.

C. To increase the number of active health workers in the field.

The first objective is difficult to quantify, suggesting little in the way of concrete tasks and functions which will involve the local people, and what is the extent
of hoped-for involvement. "Local people" is an unclear term—it may mean local people in terms of the workers themselves or may mean whole local communities. A reading of the original philosophy behind the program seems to imply both, as does the workers' job description. It's realization is subject to a clarification of what extent of "involvement" would be considered a "success" for the program. Specific parameters, such as the number of people attending planning meetings or using the health services could be used, if data were available. These values of 'consumer"involvement" and "linkage" don't provide sufficiently concrete criteria to be applied to specific decisional problems. How much is enough 'consumer involvement? How is the CHR to be a link - by working closely with the nurse at clinics? By working out in the community or with the tribal council? How much energy is to be expended to obtain consumer involvement if the Chief and Band display little interest in health problems? It would likely be subject also to the nature of the local situation. Some communities may be already quite highly-organized and administering most aspects of their community life, which would conceivably give a worker more resources to draw upon and more chances of obtaining local involvement in health matters. "Involvement" would, in one other sense, mean that more health-care givers are Indians, and a hoped-for spin-off from the program is that it will
encourage more native people to educate themselves for careers in the health field, and to work with their own people following. "Involvement" also can mean that the Band take charge of administration of the local worker - selection, hiring, firing and payment.

The second objective is again operationally quite vague. Providing a CHR as a "link" is supposed to increase effectiveness. How? By making health personnel more understanding of the consumers or devising more appropriate solutions to their problems, by making consumers more favorably inclined to heed advice or use services, by having a Medical Services representative in the community at all times even when nurses are absent?

It does suggest that there should be good two-way communication between auxiliaries and professionals and that auxiliaries will promote the activities of the professional health workers by some sort of teaching and public relations work. But clarification is again only found in the job description. This objective is more directly related to the over-all goal of raising health status, but unfortunately carries a suggestion as to the relative importances of auxiliary and professional work. The responsibility to
deliver effective health care is laid at the professional's door, and the auxiliary's work is to make that more probable, ignoring the real possibility that the auxiliary worker may directly give good health care, rather than just facilitate another person's services. Not mentioned directly here, but also pertinent to this objective, is the idea of having stable, long-term health workers in the community in the face of high nurse turn-over. This would hopefully encourage continuity of care and services and concomitant trust in the health service. As well, the auxiliary workers allow for the more appropriate use of various levels of manpower, in principle, at least, encouraging each person to concentrate on those functions he does best.

The third objective is simply a service objective, easily measured, very operational, more clear and realistic than the first two. Unfortunately, its significance is correspondingly less, for just having more 'bodies' on the payroll does not mean improved health care. However, the obvious implication is that the more workers actively supplying safe, good-quality, appropriate service, the more people will utilize the service with a resultant improvement in health status. It is especially important in smaller and more isolated communities, where a professional could not be employed full-time or might not always be able to get into the communities. The auxiliaries are sometimes employed half-time.
In Alberta, the program has moved from a few workers trained in 1962 to 18 on staff by 1974, with a further 24 receiving the first part of their training in the summer of 1975. These plus the eight Family Health Aides in more isolated reserves were the total Indian auxiliary health workers.

C. UNSTATED OBJECTIVES OF THE PROGRAM.

In addition to the formal written goals of the program, there were, as predicted by functionalism theory, unwritten goals of the program and of the individuals involved in it. Some of these emerged after interviews with people involved in the program and some after observing CHR's working on the reserves. Likely, many more would be discovered if the program could be observed more closely.

One long-term goal which the federal government was attempting to reach through this program was to avoid political embarrassment: both over the poor health levels of Indians, and the small numbers of Indian people employed by Medical Services especially at the levels where they would have input into policy-making and program-planning. Whether this program was intended as a means to move toward real power-sharing between government and Indian communities or a "token" to appease the growing Indian discontent, is not clear. The initiator, Ethel Martens, did state that the program was intended as means to fostering community development activities on Indian reserves.\(^5\) It was conceived and implemented in the 1960's by
Medical Services, Indian advice being asked for only later on, and the initiative and power seems to remain firmly in the hands of Medical Services. Willingness to ask greater participation of the Alberta Indian Association in the program was expressed, along with doubts as to their interest in so doing.  

Another hoped-for effect of the program was that the levels of health and living condition of the Indians would be raised to the point where such workers were neither necessary nor appropriate. It was not determined whether this meant that all Indian health workers would ideally be professionals eventually, or whether the level of skill of the auxiliaries would need to be raised to deal with more sophisticated communities. This program is also seen as an economical way of providing health services, and a means of allowing personnel at various skill levels to employ their skills most appropriately.

Administrative objectives to produce effective health workers are in operation. They are concerned with the selection, training, supervision and support of the workers, and although they are not listed as program objectives, they do exist. Structures have been set up concerned with these functions, and by examining some of the activities in these areas carried out by Medical Services, it is possible to infer the existence of
such objectives and their relative importance in the organization.

Although no written personal objectives for the Community Health Representatives were seen by the author, one can infer that each has her own reason for taking on this job e.g. to earn money, to challenge herself with interesting work. In certain communities, there is prestige attached to having a steady job which is all the greater if it is a government job, or one which involves working closely with white people. In other communities there is definite opprobrium attached to government work, and this did create problems for some CHR's. Each worker would likely to be anxious to establish her own legitimacy in the eyes of field personnel and her own community - indeed, such a concern was expressed by three workers although in indirect words. Nurses mentioned that evaluation was a source of great concern to the workers, not because of any gross effect such a loss of salary or the position, but because the workers wished to do a "good job". Another objective mentioned by most auxiliary workers interviewed was to increase their resources - education, skills, transportation, and support of their nurses, in order to carry out their job more effectively. Two mentioned a desire to take further
education as a prelude to professional nurse-training, though whether this objective arose because of experience in this program, or was a pre-existing desire which led them to take the CHR course, was not clear. This is one effect of the program which some of the administrators hoped for: to encourage Indians to study in the health professions and work in Medical Services at a level higher than that of a CHR. It does appear to potentially conflict with the objective of having Indians working on the reserve, closely allied to their people. Two workers mentioned a wish to belong to an association of auxiliary workers, maintaining frequent communication and contact, so as to support and learn from each other. None mentioned the association as a "union-type" organization concerned with workers' benefits or improving their educational and financial status.

There are certainly many more unwritten objectives which are held by personnel involved in the program, but time did not permit them all to be searched out.

* There is controversy in the literature as to whether further, professional training strengthens tendencies to middle-class biases in the indigenous workers, or whether he can maintain his indigenous "qualities" (special personal knowledge and understanding of his clients and their problems, greater acceptability of his service by clients) even after such education. See Arthur Pearl and Frank Riessman, New Careers for the Poor (London: Collier - MacMillan, 1965) pp. 155-184.
Those detailed above formed part of the basis for the analysis of conflicts which affect the program, and for making the concluding evaluatory comments on the program as a whole.
The first objective of the CHR program is to encourage local people to participate in the health activities in their communities. The general job functions for the CHR outlined under this objective include providing consultation, advice and assistance to individuals and groups in the community, and making appropriate referrals when necessary. More specific job functions under this objective were used by the author to derive immediate objectives for the CHR's and these are given below as the basis for examining the CHR's activities.

Immediate objectives one to seven are basically concerned with healthy family functioning. Although incompletely described by these activities, teaching parentcraft is an important part of the CHR's work. By having CHR's carrying out these functions and by encouraging parents to follow certain practices and make use of health resources in the community, it is hoped to reach the over-all objectives of improved health status.

A. OBJECTIVES A1 - A12 - HEALTH OF THE FAMILY

i. Objectives A1 & A2 - Prenatal and Immunization Clinics.

When prenatal or well baby clinics are to be held, most of the CHR's try to remind a day or two beforehand those who are due to attend, and make sure that arrangements
for transportation or babysitting can be made. The greatest
difficulty is in the prenatal area, none of the workers or
nurses being satisfied with the clinic turn-out. Women 'resent'
prenatal care, according to Florence Youngchief, and do not see
any necessity for it except for the last months of pregnancy
(Field Notes, July 24-25). On Morley reserve, the nurse men­
tioned that several older women who used to act as midwives
were still consulted by younger women regarding pregnancy.
She also expressed great frustration at the lack of response
to the nurses' prenatal clinics, but she did not have any
contact with these older 'midwives' and did not wish to work
with them in this area (Field Notes, July 19, 1975). At
Athabaska and Blood Reserves; prenatal classes had been
held a few times, although the small numbers of women preg­
nant at any one time and the even smaller numbers attending
made this activity a substantial input of the nurses' time
and energy for limited returns.

Immunization clinics met with greater success,
though there is difficulty persuading women to bring very
young babies, for the immunizations do cause some fever and
upset in the children. Mrs. Samson the CHR of Hobbema
Reserve advised the nurses to hold immunization clinics in
grandmothers' houses and the grandmother would see that all
her grandchildren were brought. By choosing different
grandmothers over the months, a fairly good immunization
record was obtained (Field Notes, May 14 & 15). On Kehewin reserve, immunization is done by the nurse on home visits, so that 100% coverage is obtained, while at Athabasca, immunizations are done when people arrive during treatment clinic hours. This combines a curative function with preventive health work, which nurses and CHR's feel makes their presence more acceptable. This latter reserve is relatively remote, so that the nurses carry out curative work as well as preventive. (On all the other less remote reserves visited, most of the nursing is public health nursing, with minor treatments such as for lice and scabies also carried out). None of the auxiliary workers did immunizations, though several expressed a desire to learn to do so. Although nurses expressed the idea that the CHR's could take on much wider responsibilities such as ear and eye screening, only one felt they should be able to do immunizations. This seems to be a function the nurses keep for themselves, perhaps from a need to keep intact their job domain, or a need to keep this as a mode of entry to Indian families for other purposes besides immunization. Most nurses were unsure about the legality of allowing CHR's to give injections.

2. Objectives A3 - Nutrition

The auxiliary workers obviously felt comfortable teaching nutrition, mainly to the elderly and to mothers.
Regina Pastion of Athabaska felt that teaching nutrition and budgeting was one of the most important areas of her work, and expressed an interest in learning to conduct cooking classes. She felt that her experience of feeding a large family on a small income supplemented by hunting and fishing enabled her to give more appropriate advice than could the nurses. The author does not know if she had mentioned her wish to learn and do more in this area to the nurses, but to this point, she had taken no initiatives about this. (Field Notes, June 10-13). Several workers mentioned that while shopping, they noted those families buying what they considered to be non-nutritious food, such as snack items and expensive convenience foods, and would remember this on their home visits to those families.

Infant nutrition is a matter of great interest to all the CHR's and they say they encourage breast-feeding, though some find it hard going - Carolya Noskiye of Bigstone Reserve says that a common reaction is "what's the use?" when the babies go away to hospital so frequently (Field Notes, June 3-6). Regina Pastion of Athabasca has another problem - mothers breastfeed children for over a year giving few supplements, and she is concerned with altering this habit, with she says, considerable success (Field Notes, June 10-13). In all these areas, the workers mentioned the need for persistence and patience.
3. **Objective A4 - Dental Hygiene**

Teaching dental hygiene was an activity the workers carried out in schools usually under the supervision of a dental hygienist. More interest was expressed in the reserves where running water was available to most people and the level of income and education reasonably high, (Kehewin, Blood) whereas it was not an activity of high priority on other, poorer reserves. Other problems were more pressing, and it was felt, probably realistically, that supervised "brush-ins" in school were the only time the children would follow the regime, since there would be little encouragement at home (Field Notes, June 3-6). A study by Stolpe and his colleagues found in a program taught to Indian school children that oral hygiene improved during the school year with instruction in oral health, but this improvement was not maintained.

4. **Objective A5 - Environmental Safety**

All workers were concerned with this objective, a safe and hygienic environment. Skin conditions, mainly lice, scabies and infections, are common in conditions of poor hygiene, and the workers regularly visited schools and homes to both treat children and instruct parents in the prevention and treatment of the problems. This is another area where repeated visits and patience are required, for the burdens are great of keeping a house and large numbers of children clean, especially when running water is not available. The CHR's seem to manage this area almost entirely
by themselves, it being relatively uncomplicated, and, it should be added, rather unattractive. Lice do not appear to hold any horrors for the workers.

Domestic and environmental cleanliness and safety is an area where the CHR's feel themselves quite effective. Several mentioned their efforts, exhaustive in a few cases, to get privies built by the Band, arrange for garbage pits or drums or a regular garbage collection, arrange for regular water service (a truck is used on some reserves to haul water to household cisterns) and to have at least annual clean-ups on the reserve to remove hazardous and unsightly litter. On Kehewin and Heart Lake Reserves, the CHR's did a survey to see which houses needed repairs and renovations, and recommended to the Chief those needing the greatest amount of work to be done. On Kehewin the nurse also noted that several houses were uninhabitable, and their word was used by the Chief to press Indian Affairs to provide funds for new housing. Florence Youngchief noted that the people like the house-to-house safety inspection they carried out - "nobody ever told them about loose chimney pipes, etc." (Field Notes, July 24-25).

The area where the CHR’s could most easily point our tangible accomplishments was in the area of hygiene, and their effectiveness depended very much on the availability
of resources to put these needed improvements onto the reserves. Teaching people, persuading them to change their practices, especially if the new practices required more effort on the part of the people was much more difficult, and produced much slower, less noticeable results. However, just putting in running water did not automatically produce cleaner houses and people, and the CHR's still had to teach and encourage especially mothers to be more hygienic. Mrs. Youngchief follows up every case of gastroenteritis seen by herself and the nurses to determine the cause if possible, and told the author that most cases were due to unclean food and houses (Field Notes, July 24-25).

The accident prevention work is confined to removing unsightly and hazardous litter from the reserve, and inspecting houses for obvious dangers e.g. faulty electrical outlets or heating systems. Even though industrial accidents are common due to the nature of most people's employment, and car accidents are common partly due to the vintage of the cars and people's drinking habits, the CHR's did not appear to have conducted any educational programs on safety. It was the author's impression that alcoholism workers or the Department of Indian Affairs had occasionally held safe driving courses sometime in the past, but CHR's were not involved in this themselves. Perhaps they
were doubtful of the effectiveness of safety campaigns or their ability to conduct such campaigns themselves.

The work carried on in this area of child-rearing is at a simple, physical level -- feeding, keeping clean, avoiding domestic accidents, obtaining immunizations. These seem to be appropriate and important learning needs for many mothers, for the problems here are frequent and easily detected. Other concerns, such as a child's normal growth and development, disciplining and behaviour problems, the need for intellectual stimulation for children, were not mentioned by CHR's -- perhaps as a result of their lack of training in these areas, because they are not common worries to parents, or perhaps because the majority culture's thoughts on child-rearing are not completely appropriate to Indian culture. These problems are not so apparent as the physical ones and are more difficult to recognize and treat, as well as not being a relevant area to tackle in many cases -- asking a mother with little education and many small children to think about their "intellectual growth" is probably not realistic. However, even where parents would be receptive to such knowledge it is doubtful that the CHR's could give very sophisticated information.
5. **Objective A – Family Planning**

Family planning is a touchy area on several reserves. Carolya Noskiye of Bigstone Reserve mentioned that family sizes were changing, that younger women were having three or four children "only", though community approval was generally for large families. She felt that the religion of the area (Roman Catholic) was not a potent force against family planning, but that the men especially were against it. Why, she did not know. She put much effort into working with several families where the women, with up to ten children each, were in very poor health. She spent much time reminding the husbands of the work-load that children meant for the wife and how she was "tied down", while it did not mean that for the men. These women were persuaded to have tubal ligations, but most women, she said, say nothing, only giving a blank face, when she brings up the topic of family planning (Field Notes, June 3-6). On the Athabasca Reserve, the CHR also mentioned the objections of the husbands and found it a difficult subject to broach, while on the Blood and Kehewin Reserves, the CHR's felt able to talk easily on the subject to women. What their effect was, they did not know. Teaching sexual hygiene in schools was mainly done by the nurses, if at all, though the CHR's advice was asked about the appropriateness of certain films and lessons by some nurses.
CHR's mentioned that the problems of illegitimate pregnancies and young marriages was substantial, but felt unsure of how to prevent them. They connected these with the problem of child neglect usually, although Florence Youngchief said emphatically that the apprehension of one's children by child care workers was considered to be a great disgrace. She also added that the white people got "too excited" about situations, and she did not think that apprehension was necessary as often as the child-care workers did (Field Notes, July 24-25). The author felt a certain ambivalence and shyness in the CHR's about the subject of birth control. Most of the CHR's are women with large families themselves; several are Catholics. They expressed the idea that spacing of children was 'healthier' for the mother, referring mainly to physical health, and did not place much emphasis on economic constraints, the opportunities for development of the children, family dynamics and so on. It was not an area they wished to discuss to any extent and the author was able to get only a vague impression of how much time they spent in this area, or how effective they thought they were.

6. **Objective A7 - Exercise**

This objective of teaching the need for regular exercise was not mentioned by any CHR's except Mrs. Samson at
Hobbema, where a weight-watchers group had been set up, and was slowly declining to the point where all but two women had dropped out. Obesity does seem to be a common problem on reserves, mostly in women and mainly due to poor diets over-abundant in carbohydrates. The idea of 'regular exercise' has a white middle-class ring to it (as do many of these objectives) for people employed in non-physical occupations and leading sedentary lives. The Indian men often work at physical labouring jobs, and if not employed, are probably as active as most middle-class Canadians anyway. Recreational and exercise facilities are lacking on many reserves, and if present, are used mostly for school-children and youths.

7. **Objective A8 - Alcohol Abuse**

In the area of alcohol abuse, the CHR's all mentioned that excess drinking was a major problem on their reserve. However only one mentioned she would like to take a course to study alcohol treatment, although all were involved in dealing with the effects of it - treating injuries, ensuring that children were fed and looked after and so on. They expressed their feelings of inability to handle alcoholics or to reduce the incidence of 'binge' drinking, preferring to leave this work to specialists. Thus their participation consisted of co-operating with either Band employees acting as counsellors, helping provincial or Indian
Affairs alcohol workers to start alcohol treatment on the reserve, or sitting on the Board of a Detoxification Centre, whichever approach is used on the reserve to handle alcohol problems. Carolyn Noskiye of Bigstone mentioned that she did attempt to get the Band to help her set up an alcohol program when she first started work as a CHR, but they were not interested until a wave of vandalism started a few years ago. She now is helping a provincial alcohol worker start his work on the reserve and has persuaded the Council to use the Band bus to pick up clients for the alcohol-treatment programs (Field Notes, June 3-6). All CHR's knew which families had problems with alcohol and made direct referrals between alcohol workers and patients. The CHR on Hobbema, which has a Band-run DeTox Centre, feels that the centre has been very successful in reducing alcohol-related marriage break-up, child neglect, car accidents, fights and so on. She was instrumental in setting up the Centre and now sits on its Board (Field Notes, May 14-15). The worker on Kehewin noted that economic development on her reserve has been very great over the past three years; this and the two alcohol counsellors, she felt, reduced alcohol problems, such as car accidents and marriage problems (Field Notes, July 24-25). It should be noted that the objective as set out by the job function "to make people aware of the dangers of alcohol abuse" is probably largely superfluous, since everyone in the communities has had contact with drinking
and seen the activities surrounding alcohol use from a very young age. There is some evidence that alcoholism as classically defined from studies on Europeans does not exist among Indians to a great extent. Lone drinkers are quite rare and individual addicted drinkers are less common amongst Indians than in other groups, while 'binge' drinking presents a large problem in terms of crime rates and community disruption.\(^2\) The results of binge drinking are obvious, whereas the dangers of classical alcoholism are not so apparent and perhaps not so real.

It is probably a realistic attitude on part of the CHR's to avoid direct involvement in alcoholism treatment, for several reasons. If a community was not ready to acknowledge this as a problem area, attempts on the part of the CHR to force acknowledgement or action might only cause resentment and alienate her from the people. Several CHR's expressed a belief that excess drinking was due to lack of employment and recreational opportunities, and they knew their ability to change such large social circumstance was limited. Even if beliefs are not objectively true, they are true in their consequences, and in the light of such beliefs, these workers might not be very effective in treatment and preventive attempts. Their supervising nurses do not work
in the field of alcoholism prevention and treatment, so that effective support or advice from them would be lacking. In effect they are not different from most health professionals who find complex social problems such as alcoholism difficult and unrewarding to work with, as results are often long-term and 'cures' less frequent than in biological diseases. In this same line, it is noticeable that there is no mention made of activities in the mental health area. Mrs. Samson of Hobbema said that she would counsel people on marriage or child-management problems if they asked. She had had no specific education in this area, but drew on her years of experience and "folk-wisdom". None of the other CHR's attempted to deal with severe mental health problems - they knew what mental health resources were available and referred people to them. It was not a problem area which loomed large for them, for no-one mentioned it except Nora Brewer of Blood Reserve, who put suicide as the major health problem. She said she felt no-one was dealing with the mentally ill and she herself was not capable (Field Notes, Aug. 21-22).

8. **Objective A9 - Home Nursing**

   This objective, giving and teaching home nursing care seems to depend on the availability of other resources. If a hospital is nearby, the CHR's prefer to take people
there, especially children. Most workers expressed concern for the elderly, but their visits were mainly for the purpose of seeing if they were "all right", or if they were taking their drugs. It seems that people were not discharged from hospital generally until they were quite completely recovered and would not need extensive home nursing, a practice resulting from hospital personnel's belief that recovery would not be enhanced by the isolation of and conditions on many reserves.

The role of the kin group in sickness is not clearly defined for Plains Indians, as it is, for example, for Navaho Indians. Presumably they, as in all societies, take notice of the illness, take some care of and comfort the sick person. However, somewhat paradoxically, this support is considerably reduced by this very practice of modern medicine of removing people to far-distant hospitals, as well as others such as examining and treating patients privately, and restricting visiting hours and numbers of visitors in institutions. The CHR's say they encourage families, if they can trust them, to carry out simple home nursing procedures e.g. bathing a feverish child, or helping an elderly person to take exercise (Field Notes, July 30).

Tuberculosis follow-up is an area where CHR's feel effective as well. Emily Wesley of Morley manages follow-up
quite independently, doing the drug dispensing and paper-work by herself (Field Notes, July 19). Others go around with the nurse and encourage people to take their pills and teach them about the disease - its signs, symptoms, prevention, transmission - often in the local language. Studies of the effects of beliefs on health behaviour have indicated that fear, instead of inducing a person to take therapeutic or preventive action, may instead act as a deterrent. A patient, ignorant of the meaning of signs and symptoms, and fearful of their consequences, may delay seeking care and information. For example, a belief is still current on many reserves that a positive diagnosis of tuberculosis means being taken off to a city hospital for several years, or perhaps being taken off to die in the hospital, with the result that tuberculosis screening programs are shunned. On one reserve the writer visited, many of the middle-aged multiparous women believed that contraceptives caused cancer, with predictable results.

On the Blood Reserve, diabetes is a common chronic complaint, especially in the elderly, and the CHR's are involved in day-to-day treatment and teaching, as well as for arranging a yearly seminar to which resource people and the community are invited (Field Notes, Aug. 21-22).
9. **Objective A10 - Transportation**

If the CHR has her own car she will do much home visiting on her own and also bring people in to clinics, for treatment and so on. It depends a great deal on the local situation - what transportation facilities are available on the reserve, if the CHR has her own transport, what the nurses' beliefs are regarding the extent of support people should receive. Some nurses feel people should take more "responsibility" for their health care and do not believe that immunizations should be carried out in the home, nor people ferried about to various services, especially if they have a car in the family. Whatever policy the nurse set seemed to be the one carried out, and the author was unable to determine if the CHR's wished or tried to change the transportation policy. Several mentioned that they would do more home visiting if a car was available for their use and Medical Services headquarters in Edmonton are seeking ways to provide cars for CHR's.

10. **Objective A11 - Screening**

Another area where CHR's are able to demonstrate tangible activities is in basic screening and physical examinations e.g. taking temperatures, measuring children's height and weight and so on. All CHR's helped at the nurse's clinic and several expressed their pleasure at learning how to carry
out more sophisticated techniques such as Denver developmental tests for children and audiology screening. The nurses seemed to vary a great deal in what they taught the CHR's to do in this area, probably because of the ability and interest shown or not by the CHR, and the nurse's own proclivities and need for the CHR's help e.g. if she is short-staffed, or a large number of people on the reserve do not speak English.

11. Objective A12 - Water Sampling

All CHR's look after water analysis, taking samples, sending them off for testing and recording results, as well as advising families and Band of actions to take in the light of results. Naturally, the importance of this function varies, depending on the water-supply of the area.

B. GENERAL ANALYSIS OF OBJECTIVES A1 - A12

Most workers spend most of their time with mothers and children, in the belief that this is where the greatest changes can most easily be wrought, and returns to effort are greatest. Educating a mother who is raising a family is claimed to give the children a healthier start in life, inculcates healthy attitudes and practices when people are young, and carries the promise of passing such habits on to their future families. In this respect the CHR's are following the examples of the traditional public health nursing, and the nurses, and the emphasis
laid by Medical Services on maternal and infant care, child immunization and hygienic environments. In fact, very little patient-therapist contact occurs between men and CHR's. It could be a function of traditional male stoicism and the place of women—a man might be reluctant to admit weakness to a woman. It could be an effect of the belief that most of men's 'non-medical' problems such as drinking are due to social conditions, which the CHR's are in no position to affect e.g. the lack of formal employment, the usurping of the male role by welfare, schools, government, and the social rewards for deviant behaviour. The CHR's are mostly women who have raised or are raising their own families and can add years of practical experience to their short training course to give them a feeling of confidence when working in this area. It is very satisfying to concentrate work here, for results can be seen quite quickly and dramatically e.g. cleaning up skin infections, preventing water-borne disease by teaching a mother hygienic infant feeding.

In their emphasis on contact with mothers and children, the CHR's are in agreement with a study by Lewin, in which he concluded from attempts to change wartime food habits that housewives stood in the important "gatekeeper position". It was
their system of values and beliefs that determined what would eventually be the type of food consumed. Similarly, Tyroler and his colleagues, studying levels of tooth salvage for individuals within families suggest that maternal influence is maximal in the area of family preventive health behaviour. The emphasis on these obvious physical problems of mothers and children may be due to another pressure. Scott suggests that a subtle displacement of goals can occur in service organizations. Ideally, the form and content of agency programs are determined by the client, changing with his needs. However various pressures alter original goals and policies, such as the need to preserve the organization or the absence of clear criteria by which to determine if the agency is or is not implementing its goals. Service agencies must demonstrate that they are successful in meeting their goals, i.e. they are effective in helping solve the problems of their clients. Thus a process of selection for those clients with the most easily-solved problems operates, while the most handicapped, who present the greatest challenge to the organization's effectiveness, may be comparatively ignored. The agency workers may simply not have the knowledge and skills required to deal with the most difficult problems, a frustrating experience which leads to mutual withdrawal. As well, those in greatest need of assistance are often those least
knowledgeable of the complex organizational rules of the game and can take the least advantage of services. They find it difficult to interact with personnel who deal with them in an impersonal, segmented rationalistic way, for their customary milieu is personal, local, non-intellectual and non-segmented. The concentration on mothers and children may be also a help to legitimizing the program or public health activities in general, for the Indian society seems to be quite child-centred and the communities take great interest in the welfare of children.

For chronic problems such as tuberculosis, diabetes and those affecting the elderly especially, the CHR's seem very valuable. Although scientific medicine may not be able to always improve a person's health status or cure him, the CHR can provide the continuous monitoring and support which can prevent or retard deterioration. These are areas which are traditionally "let go" by public health nurse, when acute problems arise, especially in children, which they often do on the reserves. They also require much educational and motivational work, perhaps more than parentcraft teaching does.

The educational work has two important effects: to give correct information and to instil a belief that effective
action is possible. Combining the preventive work with curative work, i.e. having visible, tangible evidence that the worker really is "working" has important benefits too. "Just talking", for most people and perhaps more so for the less educated who do not habitually deal with abstract concepts, is not valid "work". One of the major motivational orientations found in Indian society is that of "utilitarianism" or the ability to grapple with problems in a resourceful manner with a minimum of abstract speculation. This has implications for the teaching of both Indian clients and health workers.

Almost all of the CHR program's objectives, and thus the job functions of the CHR's, share two characteristics of public health and preventive work. The results of many public health activities are characterized by their "non-appearance". Their value is thus not apparent - a woman who has never seen a case of diphtheria does not necessarily see the importance of diphtheria immunization. If the individual does not see his susceptibility or the seriousness of the threat, and the situational factors affecting personal convenience or effort required are such that much energy is required on the client's part, the likelihood of participation is low.

As well, most public health activities have no results which are immediately tangible - effects are long-term, which
again reduces the "selling" value of preventive activities. This is especially important in light of the traditional Indian attitude to time, as well as the modern attitudes. Native people, lacking a written history, had a concentric rather than linear conception of time, wherein important events were remembered whether they happened in the immediate or far-distant past. The future was largely unknowable and uncontrollable. Foresight and planning were of little benefit in most areas. Orientation was thus mainly to the present. To the extent that this attitude still exists, it has an obvious effect on planning and saving activities, and on the day-to-day round of living which is fairly unscheduled and not coordinated by clocks.

This has implications for those teaching CHR's, for the workers will experience only frustration and dismay at their own lack of effect if they anticipate great or obvious changes due to their efforts. The workers did talk about the fact that only continual, slow prodding and much patience could achieve changes in some areas, and all had families whom they said heeded little of what the worker taught them, but whom they continued to "bother their conscience, anyway" (Field Notes, May 14-15). They learned to content themselves with small changes. A study by Kelman and Houland showed that changes were greater when the source of the changes presented his influencing effects more than once. Family and neighbourhood networks are important for this reason - that contact between members is renewed at frequent intervals and the
credibility of the change-source is reconstituted. The CHR's felt that the more contact people had with people outside the reserve, and the more contact with mass media, the easier it was to persuade them to adopt new habits. In this they were concurring with some research done on the health behaviour of groups of people, such as Suchman's study of people who had recently undergone some form of serious illness. He divided them into two groups: "parochial" and "cosmopolitan". The parochial group exhibited higher ethnic exclusivity, family orientation to tradition and authority, and friendship-group solidarity. The cosmopolitan group were more open, instrumental, individualistic, and had a higher level of scientific knowledge about disease. It was found that the parochial group tended to underestimate the seriousness of their signs and symptoms, and were concerned about the interference with their social functioning. They conferred about the illness with their lay reference group and delayed seeking professional care more than did the scientific group. Social isolation bred "medical" isolation, and the lack of scientific information about disease, the narrow outlook and lower expectations in general resulted in lower health horizons. The socially isolated tended to conflict more with the medical and public health professionals, being less in agreement for example, with the purposes and practices of well-child supervision, and not putting the same value on health care as the health professionals.
Public health programs have traditionally been conceived and implemented by middle-class people and directed at the lower class. They embody the Protestant ethic of activism and are concerned with inculcating in the individual a strong sense of personal responsibility for one's own health. This contrasts with the traditional Indian belief that much that happens is due to external forces and if something unfortunate does happen, the kin will see one through. The middle-class emphasis on cleanliness, and on patterns of child-rearing which feature a good deal of control and supervision by the mother contrast with the more casual attitude of the poor and the Indians. These are all potential sources of clash and frustration between health workers and Indians. 

This last point re middle-class ethics is a fundamental basis for the whole program, and one of its fundamental weaknesses. It will be returned to later on in the final chapter.

C. OBJECTIVES A13 - A20 COMMUNITY AND GROUP FUNCTIONS

1. Objective A13 - Health Classes

Under the same over-all objective of encouraging local people to participate in health programs, the CHR's have functions relating to groups rather than individuals in the community. The first immediate objective here is to teach health classes in the federal schools. All the CHR's visited mentioned this as a useful activity, though it was confined to teaching children in
the first grades, in their own language usually, about hygiene and nutrition. More sophisticated teaching for the older grades e.g. about matters of sexuality, was done by the nurses. Mrs. Samson of Hobbema added an interesting twist - she used to go around with a minister to surrounding white schools and talk about the reserves and Indian people to the children (Field Notes, May 14-15). The CHR's did not mention that they had much contact with teachers, most of the interaction occurring between the teachers and nurses, which seemed to be a fairly typical pattern i.e. CHR's confined much of their work interaction and referrals to nurses or other Indian personnel. They seemed to feel uneasy with the idea of directly referring clients to other white professionals. White people working in capacities other than health did not know the functions of CHR's and preferred to work with known entities, such as a nurse (Field Notes, July 24-25).

2. Objectives A14-A15 - Development and Use of Educational Aides

The next objectives concerning health education to groups and the use of films, posters and mass media produced varied results. The older CHR's with seven to ten years experience all mentioned that they used to do more group teaching, bringing in films and holding teaching sessions. Mrs. Samson from Hobbema now restricts this to a health 'display' at home
and school meetings. They felt it was a great deal of work for usually poor turn-outs e.g. two to four people, and felt individual teaching was more satisfying and effective. The more recent CHR graduates mentioned trying one or two projects but evinced little enthusiasm for them. For example, on Athabasca, a nighttime meeting was held for elderly people, to which a large number came. The CHR and nurses checked their height, weight, eyes, blood and talked about health problems of the elderly. To the next session they advertised, no-one came, and they had given up the idea. The author did not say that this was probably not anyone's idea of an entertaining night out, and Mrs. Tailfeathers on the Blood Reserve has had much more success with a recreational program for the elderly - bingo, dances, music - where health teaching can be carried out very informally, if at all, the main emphasis simply being on healthy recreation (Field Notes, Aug. 21-22). Nora Brewer utilized a local Indian newspaper to write articles on health and to advertise the community clean-ups, healthy baby contests, garden contests etc. she organized. She is a very articulate young woman who was leaving work to take registered nurse training in the autumn of 1975, and was one of the few CHR's who felt confident with English, and had a local newspaper and radio available to publicize articles on health (Field Notes, Aug. 21-22).
It is likely that CHR's would use mass media more, or printed media at least, if they felt it useful and if they themselves were receptive to this mode of information. It is interesting to note that most relied on the nurse's instructions or answers to specific questions for their information. Nursing books were generally beyond their comprehension and none evinced much interest in newspapers or magazines, including a former CHR news magazine, now defunct. They are being realistic in their lack of use of printed material if most of their clients read English poorly. A study of low-income groups receiving public assistance by Brightman and his colleagues found that this group relied very little on mass media for health information, but made heavy use of their physicians, nurses and caseworkers, even though the latter had no formal training in health matters.

3. Objectives A16-A18 - Band Council Meetings and Health Committees

The objective to attend Band Council meetings was fulfilled by all but a few CHR's. The exceptions occurred where the Council was "traditional and do-nothing" according to the nurses and CHR, and through which little could be accomplished anyway. In these reserves, the Chief and Council would not give notice when meetings were being held, so that attendance by the community and CHR was rather occasional (Field Notes, June 3-6, June 10-13). This objective seemed to fit hand-in-glove with the organization of a health committee, who
presented, along with the CHR, the health concerns of the community to
the Chief-Council. All felt that health committees and Band meetings
were a most important means to arousing community interest in health.
Not everyone had a health committee to work with, though it was the
author's impression that those who did not work with a committee pre­
ferred home-visiting and one-to-one type of work and did not have the
self-confidence or political connections that others did. One nurse
explained the importance of health committees by saying that everyone
is ascribed their 'place' in an Indian reserve by birth and can reach
only some people from that status and position, and never other
people. A health committee enables the CHR to reach a wider spectrum
of the community through its members. This is very much in agree­
ment with Sanders, who states that participation in the decision­
making process should occur at all levels of the power grid, for the
ordinary citizen has power to withhold support simply by not being a
client, and key people in power cliques have limited time for part­
icipation and much competition for their sponsorship. As well the
pressures for economic development on most reserves would occupy the
time and interest of the Band Council, and leave little energy for
health matters without a health committee.

Several CHR's proved their usefulness to the Chief and
Council by doing housing surveys and recommending to the Chief
which families were most urgently in need of housing help. The
support of the nurse and health committee helped to get funding for
new houses. Most had gone through the Band administration to get some sanitary facilities and services on the reserve. Some seemed to have come to a halt after accomplishing that. Especially if the members of the health committee or the CHR were related to Band administrators, and the Chief and Council were interested in health matters, there was regular attendance at Band meetings and collaboration on a variety of projects between the Council and committees.

Several CHR's said that this was a difficult thing for them to do, to stand up at meetings and badger, complain or whatever to the Council, especially since many reserves are "chauvinistic" places, and politics is the preserve of the men. The urging and support of the nurses helped them a great deal they felt. Carolyn Noskiye would either speak for people at Band meetings who had complaints or problems, or else went along with them to the meetings, supporting them verbally and morally (Field Notes, June 3-6).

4. **Objective A17 - Group Work**

The next objective, to form or support groups in the community to improve health seems to have fairly limited success on most of the reserves the author visited. A few have homemakers clubs and one has a weight-watchers' group, all of which are rather faltering at best. On the more organized and sophisticated reserves, such as Hobbema and Blood, the concerns regarding alcohol, housing, recreation and so on are managed by the Band, and CHR input seems only sometimes to be welcomed and given. Mrs. Samson of Hobbema sits on the board of the De Tox Centre, Mrs. Youngchief of Kehewin feels
free to contact the Chief or pertinent councillors about particular problems. She tried to start a teenagers' club, but it failed she said. On Athabasca, Regina's attempts to have a regular get-together for the elderly failed. The CHR's support any attempts by others to deal with alcohol. They seem to regard recreational functions such as bingo or sports activities as good things, to keep people from drinking mainly, but are not themselves active in these areas.

5. **Objective A19 - Workshops**

The next objectives seem to be two of the least frequently performed. Organizing or teaching workshops and securing funds for them is a fairly complex undertaking and could probably not be done without a good deal of support from the nurses. Miss Frenchman of Heart Lake was planning a workshop on child and home management, nutrition, safety and hygiene if funds came through from Indian Affairs (Field Notes, July 30). On the Blood Reserve, Nora Brewer was active in organizing healthy baby contests, garden contests and community wiener-roast-cum-clean-up, and she and Mrs. Tailfeathers actively helped with the yearly workshop on diabetes (Field Notes, Aug. 21-22). The other CHR's did not mention activities in this area.

6. **Objective A20 - Interdisciplinary work**

As far as working with community leaders and workers, and with government officials, the functions of the CHR have already
been commented on. Co-ordinating activities with other community workers was done on an ad hoc basis, as a patient's need dictated. Most were reluctant to contact government officials themselves, preferring to go through the nurse, and none mentioned that they wished to or had tried to integrate health services more closely with other programs on the Reserves. If the various professionals on a reserve operated in a certain mode, that is to say, maintaining the traditional relative isolation of health, education, recreation, social work, and whatever else was happening on the reserve, that is the way in which the CHR operated too. Hobbema was an exception, where the nurse-supervisor and CHR were closely involved in school affairs and the development of youth counselling services (Field Notes, May 14-15).

D. GENERAL ANALYSIS OF OBJECTIVES A13-A20

Objectives thirteen to twenty are basically oriented to trying to get Indians to take more responsibility for their health, both individually and collectively. More success is claimed for changing individuals' attitudes to health. For collective responsibility, there seems to be a fair measure of success on some reserves, as on Morley where the health centre is administered to a great extent by the local people. In other reserves, there is little activity in health or other areas of community life. A number of variables which would affect the
success of these objectives become obvious, if Indian culture and history before and after contact is known.

In most Prairie tribes when the Europeans first arrived, no authority of a political nature was present. The individual was expected to rely upon his own resources to provide for himself. The children were trained to do things for themselves with minimal help from others. Self-reliance and a hesitancy to intervene in the lives of others resulted. The accompanying form of social organization, wherein small groups lived together for short times only, breaking up to carry out hunting and gathering activities, permitted limited interaction with others outside the nuclear family. Formation of voluntary sub-groupings along political, religious or occupational lines was inhibited. This ethic of non-interference and lack of habits of activism in certain spheres worked against the Indians controlling their affairs later on, after contact with the white man. It could be a factor in the difficulty on some reserves now initiating group activity in health and other areas.

Activity and work were not valued in traditional society for their own sake, and thus practicality and the notion of progress were devoid of an underlying raison d'être. Traditional ethics of feeling, intuition and fate often conflicted with industrial ethics
of observation, measurement, planning and reason. Because of the lack of occupational hierarchy in traditional societies, Indians did not base improvement in their personal status on such factors as work, achievement, success and scientific rationality. Work was an activity enjoyed for its own sake, but hard work rather than steady work was the rule, with certain periods of the year reserved as rest times. A dependence on nature, a passive acceptance of it and emphasis on maintenance of the status quo in harmony with natural forces is the dominant motif of the traditional culture. Remnants of these beliefs and values are still extant in Indian communities, as demonstrated by varying reliance on magic or spiritual means for healing illnesses, a dislike of indoor, "routine" work, dislike of direct confrontations, and disinterest in accumulating large amounts of material goods. However, these values and beliefs exist to varying degrees and it is not possible to generalize about the "traditionalism" or "assimilation" of the Indians. This again points up the value of flexibility in the CHR program and other Medical Services programs.

Up to now, and still today on many reserves, the planned changes in Indian society have been directed strongly by outsiders. The motivation and design of change have emerged from non-Indian hands, remote in terms of geographical, social and cultural distance.
The control and the direction of the policies have been inconsistent as different governments instituted different measures, and even capricious as the government agents, various religious bodies and charitable organizations became involved.

The relationship between the dominant society and the Indians has been essentially that of the "administrators" and the "administered". Native leaders have had their position weakened by various practices such as government officials bypassing the Chief to deal with individuals by themselves, leading the people of the community to interpret this as negative evaluations or disrespect of their Chief. There has also been considerable development of "token" leaders, those with some oratorical ability being put forward by the Band when outsiders request it, but having no real authority. Another salient factor is that the more acculturated or the more vigorous members of the group tend to emigrate, leaving behind the more traditional, usually older and conservative Chiefs to rule. This helps tribal organizations to stay intact, but can hinder those trying to innovate programs. Often the reserves has as Chief a hereditary leader or one who is head of a large family, and not really an able and active leader. Frustration only can result when health personnel try to interest more traditional and inactive Chiefs and Councils in their work, and it may be more profitable to expend their influencing efforts on informal leaders in the community.
This has meaning in light of the research which shows that the tendency to adopt new practices is greatly influenced by group opinion. Leaders who give information personally in face-to-face situations, and those most likely to innovate are thoroughly integrated into their social or professional institutions, where they come in contact with the opinion-leaders. It is thus important that health workers establish rapport with respected leaders or else themselves be one of the informal community leaders.

There is a parallel to this dominance of white over Indian, and that is the role of health provider and consumer. Bureaucratic systems believe in performing a service, and assume that a person coming to them will take on the traditional sick role i.e. he is willing to have his problem solved and will allow the system to operate fully and will play the role outlined for him by the system. Clients failing to live up to this norm may be classified as "unco-operative", and service may be curtailed or altered in some way to make the situation more satisfying to the care-giver. To what extent this operates on reserves in light of the antipathy felt by some Indians and whites to each other is not documented.

As Poslun notes, it is difficult to end dependence without threatening the people who have become addicted to the
exercise of authority. Professionals are used to having a good deal of control over their own activities, and white Canadians are used to having a good deal of control over Indians. This whole area of developing indigenous leadership requires a fine distinction between stimulating the Indians' desire for something and supporting them in their attempts to achieve it, and taking over a project, even if subtly, and doing it oneself.

Whichever way is chosen, both the health professionals and the CHR will experience difficulty. The out-group antipathy leads to ridicule and contempt of those Indians who openly try to emulate white society (not to mention work for it), yet the traditional norms of the community are waning even within the confines of the community. Group support for whichever way the individual chooses may be lacking. The old moral responsibility for one's own spiritual welfare is still present, but the source of it, a consistent upbringing based on supernatural values is missing. Internal controls have broken down and traditional techniques for social control are now inadequate. There is little incentive to upgrade the social conditions which influence the moral aspects of another's behaviour or to confront persons with the consequences of their behaviour upon other persons or the society at large. This is one reason why attempts to form voluntary groupings to deal with health,
educational, religious, occupational or other matters are frequently unsuccessful. It poses a large problem for action programs, which to be successful must be desired by the people as well as planned and executed with their participation.  

Most of the workers prefer to spend the majority of their time in activities which allow one-to-one involvement, rather than in group work. They find this more satisfying and appear to think it more effective and economical of their time and energy. They are supported to an extent by studies on the importance of personal influence (which presumably would be greater if the CHR is concentrating on one person instead of dividing her attention among a group) which show that this is especially important for "late adopters", or those slow to accept changes. The CHR's as a rule seem to feel that they can better influence individuals to become more interested in and responsible for the health of themselves and their family rather than to influence a community by collective means. There are, as always, exceptions, and the art lies in determining which method is most effective for that community.
CHAPTER VI
CULTURAL LINKING

The second objective of the CHR program is to increase the effectiveness of professional health workers by providing a link with the local community. From a very simple function such as introducing a new nurse to the people and places on a reserve, to the most subtle attempts to persuade indifferent Band leaders that a new program would be beneficial to the people, the CHR's play, according to Medical Services personnel, a most valuable and appreciated role. The specific job functions outlined for the CHR have been used to derive the immediate goals designated as B21-B24.

A. OBJECTIVES B21-B24 THE LIAISON ROLE

1. Objectives B21 and B22—Cultural Bridging

Interpretation of language and behaviour was carried out frequently by all CHR's. Carolyn Noskiye said she explained to people who complained of long waiting lines at some clinics about the nurses' busyness, and explained to the nurses that lack of transportation and clinics held during children's nap-times led to lack of turn-out at other clinics. This CHR had a difficult time with the Band Council, who accused her of "working for the white man", but she merely laughed and said she didn't care, that the patients didn't think so. The Council previously fired two CHR's for working too much "with the nurses", so when a few friendly councillors advised her to become a civil servant instead of a Band employee, she did so. (Field Notes, June 3-6). The first evaluation
of the CHR program, carried out in 1964, also mentioned that traditional community suspicion of "white men's ideas" led to difficulties for the CHR, including hostility from leaders and refusal to co-operate with programs.

The nursing supervisors on Blood and Hobbema Reserves mentioned that the CHR's were especially valuable to get through to particularly "difficult" people, the unresponsive or hostile, or simply the non-English-speaking elderly. They were expressing the idea of the linking function of the CHR, who may be for certain people their main point of contact with outside sources of information. Being influential in a system seems to be related to who the influencer is (the personification of certain values); what he knows (his competence as perceived by others); and whom he knows (his strategic social location in the system). By working in the Medical Services system, the CHR is in touch with outside sources of information and has the potential to be influential on this basis. However, it is also important for an influential person to be well integrated into a system's structure of interpersonal relationships - a point well-recognized by the nurses who felt that, for example, Mrs. Samson's work was not hindered by her being married to a former Chief. Opinion leaders are more innovative, more in contact with outside sources of information, of a somewhat higher social status, and more socially and physically available for social interaction. Thus the emphasis on selecting people for CHR training who are seen as "helping" persons, known and respected by the community.
On Hobbema, the nursing supervisor mentioned the value of CHR's in "politcizing" the nurses i.e. making them realize the importance of family connections in Band politics, and the reasons for the various machinations which go on in the Band administration, both necessary knowledge for working on a reserve. She asked her CHR's opinions about planned programs such as the appropriateness of various health education sessions and the timing and location of clinics, and felt that the CHR was effective in gaining more respect for and understanding of the nurses and their work.

Card et al. claim that much of the social interaction associated with government is nomothetic, or conditioned by law - the local persons don't have to be "sold", only "told". This type of interaction requires little exchange of views or knowledge, and minimal consideration of attitudes or opinions. Though the process may be softened somewhat by conventionalities, congenial conversation or persuasion, often it is characterized by curtness, brevity and a reliance on threats, especially when low-status people are involved. This type of interaction is not confined to government. It is a usual pattern of behaviour in Indian families, and the religion of the area may also function in this manner. One might make a case for it being a common form of interaction between health professionals and clients.

Other types of interaction occur of course. Gossip is a frequent mode of communication, especially where there are great social distances between people and language difficulties exist. People of limited
education, subject to the nomothetic type of interaction discussed above, have restricted opportunities to obtain accurate information about various happenings. Rumour substitutes for knowledge in many cases. Interaction characterized by patient persuasion, free discussion and collective planning is limited by the considerable time required for such discussions; the lack of skill or training in such type of leadership in government workers; wide-spread apathy towards areas of supposed concern to the community eg. schools, health services; language difficulties; hostility to white people and so on.

The CHR's all emphasized that people would talk more to them than to the nurse; this and its reverse was corroborated on more than one occasion in front of the author's eyes. For example, on a home visit on one reserve, the nurse, on a tuberculosis follow-up visit, walked into the house without knocking as is the custom, handed out pills to everybody and watched while the mother, a large baby strapped to her back, wanly tried to force the rebellious children to swallow them. The nurse after a few moments of watching the melee, turned to leave, while the CHR just stayed and casually chatted with the mother and children in the local language. After five minutes of seemingly desultory conversation, the CHR mentioned several problems the woman had talked about, gave the reason they had missed their last clinic visit, and appeared to be quite satisfied with the visit, though she planned to return that afternoon to reinforce her health teaching on tuberculosis (Field Notes, June 10-13). Such simple hints as telling people to take drugs morning, afternoon and evenings instead of after meals (some people eat only twice a day) and explaining the position of certain people in the reserve hierarchy so that the right people are
approached for information, are important for smoothing relationships between nurses and local people.

2. **Objective B23—Use of Resources**

The next function in this area is to advise people of the community of the health and other resources of the community, and to help them to use them. Most of the CHR's said that people telephoned their home or stopped them on the street, asking their advice on problems. The CHR at Athabasca said that people will ask her if it is "all right" to consult a nurse about a particular problem, especially if it is not strictly a medical or physical problem. The CHR's did not seem to discourage people from using local medicine men, and said they would inform the nurses which people were using indigenous medicine for particular problems, so that the nurse could encourage them to use that plus Western medicine if she thought it appropriate. The knowledge of and respect for indigenous medicine makes it more likely that people will look favorably on Western medicine, the nurses and CHR's believe (Field Notes, June 10-13, July 23-25, and Aug. 21-22).

Work on cognitive dissonance suggests that the carrying out of an action, such as utilizing a service, may alter beliefs. This could be used by health workers as an alternative to directly attacking attitudes or beliefs. Trying out modern medicine as an experiment may result from such sources as reports of others or the kindliness or interest of a health worker. If a treatment is effective, the pragmatism of people will usually lead to continued use, and eventual acceptance of the beliefs and knowledge behind the procedure.
As noted before, the CHR's encourage people to make use of resources generally, but rarely refer them directly to other workers, especially white professional workers. They also did not mention that they encouraged people to demand resources, but rather saw it as their function to articulate needs and desires to the nurses or Band administration. Medical Services personnel generally expressed appreciation for the role of CHR's in encouraging people to use facilities wisely, but also implied that they were willing to contend with only certain demands. This can be a difficult role for the CHR, for if she finds many problems she cannot ignore, and brings them to the attention of the nurse, the nurse may dislike the extra work load this implied, or find that she or Medical Services does not have the resources to meet them - a frustrating experience for all. The CHR might be subtly discouraged from bringing such problems to the attention of field personnel by the non-response, or may be viewed as a "rabble-rouser". It could also have the effect of forcing nurses or Medical Services to examine their goals, norms of operation, their prejudices - a potentially uncomfortable process as well as a potentially beneficial one.

Factors besides beliefs, motivations and cues which affect the decision to use services include the availability of treatment resources, their physical proximity, and the monetary and psychological costs of using them. Psychological costs include such things as stigma, humiliation and social distance between client and practitioner. Having local people as CHR's always available and reasonably mobile, is an attempt to reduce these costs.

Other factors, such as the tolerance threshold of those who are exposed to and evaluate the signs and symptoms, affect the response made to them.
Often noted in the literature is the Indian lack of affective response and stoicism in the face of pain, hunger, fatigue and other stressful situations. Cultural patterns and lack of knowledge also affect a person's perception of the seriousness of illness, but the relationships are not very clear. Differences between classes in the interpretations of signs and symptoms of illness have been found. The lower-class delayed seeking treatment more, and seemed more willing to "put up with" their symptoms. They also feared certain diseases more (tuberculosis, cancer, arthritis, birth defects) than those with higher incomes, a factor attributed to the greater knowledge of the disease and its treatment in the upper income groups.

All of these may cause the Indian clients to use the health services in a way which health professionals may consider "inappropriate".

As well, Rosenstock has pointed out that health-related motives may not always give rise to health-related behaviour, and conversely, health-related behaviour may not always be determined by health-related motives, eg. attending a nursing clinic in order to partake of the free coffee. An important point is raised by this research on beliefs and motivation. Should programs be oriented to fit with existing beliefs and motives, or should attempts be made to change people's beliefs and motives in accordance with professional ideas of what is needed? The latter presents problems ethically and procedurally. He suggests that where motives are weak, especially re prevention, other motives should be tapped, such as social, parental, sexual and economic. And since therapeutic care is more important to people, purely preventive work, including health education, could be combined with curative work, done by people in a place identified with curative work, such as doctors and nurses in a hospital. This could
be especially acceptable for people who handle their life situations on a day
to day basis. The CHR program seems to be attempting to do both i.e.
accommodating professional ideas of health needs and healthy behaviours, with
local and indigenous practices, via the CHR's, although the end results
aimed for are preponderantly those of the health professionals.

3. Objective B24—Sensitization

This last objective is not mentioned as a function of the CHR's
themselves, but does occur as a result of fairly close working relationships
between nurses and CHR's. The nursing supervisor on Hobbema stated the
idea most succinctly of all the nurses when she said the CHR's could
sensitize the nurses to their own biases and prejudices, which they may
hold unconsciously (Field Notes, May 14-15). These biases can be
beliefs held by the middle-class about the poor, beliefs about professionals
versus auxiliary activities, beliefs about Indian culture, attitudes of
paternalism, or appropriate ways to help the Indians and so on.

Schneiderman, in a survey of social science literature listed
attributes of the poor he found therein. The lower class were seen by
higher classes to have destructive patterns of speech, dress, marriage and
family life. Though they were thought to desire money, possessions and
prestige, they did not know how to achieve it. The poor were seen as not
motivated to use services, lacking awareness of problems and the way in
which services could be utilized, making "inappropriate" requests for
services because they were unable to understand agency policy and programs.
They had a bad reputation with the higher classes, who labelled them
dirty, lazy, unambitious, unwilling to save, sexually immoral and disres-
pectful of the law and the other classes. The upper class felt that the 
poor liked their noisy and crowded huts, that they produced far too many 
children and most of the juvenile delinquency in society. He concluded 
that there was much evidence to indicate that clinical judgment is infused 
with middle-class bias. Such attitudes to the poor would conceivably be 
present to an extent in the health personnel working on reserves, as most 
are from a middle-class background, especially if they are not aware of 
the sources and functions of the culture on the reserve.

Most people are ethnocentric in their first contacts with and 
approaches to an alien way of life, the strange culture appearing 
incongruous, misguided and "wrong", and the people ignorant and super­
stitious. Such a derisory attitude, even if largely unconscious, can be 
a formidable barrier to communication in public health work. ¹¹

The nurses make up some of the outsiders who live and/or work 
on the reserve who are usually employees of government agencies or 
Hudson's Bay, or part of a religious organization. A substantial portion 
of these are immigrants to Canada, others are transferred to these areas 
by the civil service. Interest in and enthusiasm for their situation is 
variable. All have high-status positions on the reserves as representatives 
of powerful outside organizations. Dunning ¹² notes that many developments 
leading to change on a number of the reserves must be funneled through 
these people, which increases their prestige and gives them inordinate 
power in the eyes of the natives, though they may be relatively junior 
employees in their organization. Status for natives may be attached to 
contact with them. Because of the isolation of many reserves, these agents 
are unhampered by many of the social and organizational checks which impinge
on their behaviour in less isolated areas. They have power, comparative luxury and are superior in their technical knowledge. Individualistic interpretations of the regulations and laws they are enforcing allow them to be more rigid or more flexible, varying with the situation. These factors easily allow the exacerbation of authoritarian tendencies, though they may be disguised in the form of paternalism.

Reactions of natives may be submission (leading to a label of "good"), evasion, rejection, or attempts at exploitation (all leading to a label of "bad"). This is partly a result of constraints arising from the agent's position as an employee of an organization, for the more successful he is in carrying out programs based on organizational goals, the more favorably he is evaluated by the organization. The greatest number of furs brought in to the Bay, the largest number of babies brought into clinic, are avenues to promotion.

An area where differing attitudes between whites and natives causes friction is that of welfare and relief. Indians generally perceive that the government, Hudson Bay and the churches have been exploitative and destructive of their lands, morality, culture and so on. They may thus feel that welfare is their just due, and not a shameful admission of weakness of some kind. As well, a considerable amount of shrewd calculation goes into the decision to take a job or welfare, for balancing a steady income against time off for participation in holidays and customs, picking up odd jobs, fishing and hunting in season and a certain amount of welfare, may find a steady job losing out to these other considerations. This is an example of planning for the future which may not be recognized as such by middle-class people, but viewed as "exploitation" and "laziness".
The CHR's, by pointing out a different way to view phenomenon on the reserve may help the professional workers to at least understand, if not condone, behaviour, and put them in a better position to decide whether to attempt to change behaviour or not, and give them ideas as to how to do it.

B. GENERAL ANALYSIS--CHR ACTIVITIES IN OBJECTIVES B21-B24

The second program objective was one universally commented on by nurses and CHR's as an important and valuable part of their work: to be a link with local people in order to enhance the effectiveness of the professionals. There are three barriers to cross here: that between Indian and white, between lower and middle-class, and that between care-giver and client. The CHR's function in all three areas.

The difference between the patient's beliefs and the health worker's gives rise to what Friedson calls the lay medical culture and the professional medical culture, each with its own referral system, or network of consultants from which people seek health information. He points out that the degree of congruence between the two cultures will determine how meaningful the diagnosis and prescription are to the patient, and whether the advice will be followed. Once symptoms are recognized, the interpretation a person gives to them will determine his subsequent behaviour. If a person has definitions of illness which contradict those of a professional culture, his referral system will not lead to a professional practitioner, but to a folk practitioner, except in the case of either very minor illnesses or in life-threatening situations when other resources have failed. A patient, once he consults with professional practitioners, may find that control over the ensuing procedures has passed
out of his hands - he may be given services he did not ask for and does not understand. Yet Freidson points out that health professionals practising in an area where indigenous referral systems are extensive must bend themselves to the lay culture to an extent, or they will have few clients. Health practitioners working in cross-cultural situations find they have greater success working as adjuncts to indigenous traditional practitioners, accepting and incorporating them into the treatment framework.

The choosing of alternative systems of health beliefs and practices has been outlined in some detail by anthropologists for some cultures. Where both popular and scientific beliefs about health and disease co-exist in a community, it is usually found that modern medicine is accepted for acute incapacitating diseases, and popular medicine is employed for chronic diseases - a very pragmatic approach, as this latter category is where scientific medicine is least effective. The naturalistic or supernaturalistic explanations of etiology may persist even while modern treatments are incorporated into the practices of the people. Eventually scientific practitioners, after gaining the confidence of people by treating them effectively while at least conceding the possibility of the reality of the popular explanation, can break down the traditional-modern dichotomy. The impact of these attitudes and beliefs on Indian patients and the roles of the native and professional health workers will be variable, but the effects are likely to be present in some form to some degree. Little systematic information about the persistence of traditional medical practices is known for Plains Indians. Most nurses and CHR's visited knew that a few medicine men still practised their art, but they knew nothing about the extent and little of the content, and had not set
up any social or working relationships with them.

The native medicine men seemed to be mostly herbalists, though a few may be also diagnosticians, depending on supernatural forces to indicate to them the source of the illness. It was recognized too that the medicine men would recommend without apparent conflict the use of modern medicine for certain diseases. On a few reserves, local midwives were consulted for advice both pre- and post-natailly, though almost all births took place in hospitals. Little was known of their influence or the knowledge they imparted to women. It seems to be kept carefully away from the purview of the white man. One CHR remained convinced of the efficacy of a traditional poultice for the treatment of colds, and used it regularly on one of her children who was prone to colds.

Anthropological research reveals that traditional practitioners can have enormous influence on their clients. Because they are a part of the patient's community, they are able to see the total environment of the patient and his troubles more clearly than an outsider, and are more aware of the significance of various relationships to an individual's illness. Though they are not "traditional practitioners", the native auxiliary workers often supplied intimate information about the environment and situation of certain patients whose behaviour was puzzling or frustrating to the nurses, which made the reasons for behaviour clearer and led to new strategies, or cessation of attempts to intervene.

Traditional practitioners, as well as having a good deal of information
about the patient, may take a detailed and personal interest in the patient, making home visits and talking about the illness and its treatment in language and concepts which are familiar. Their function in reducing anxiety and providing psychological care can be an important adjunct to the bodily treatment provided by modern medicine. To a religious native, the ritual "forgiving" and support provided by the local curer is needed to regain correct "balance" in the total environment.\(^{19}\)

The CHR's activities here can only be guessed at. The comments they made about visiting casually in people's homes and the fact that their family relationships included often a good deal of the reserve population intimates that their functions had some similarity to those of traditional practitioners.

Besides interpreting between lay and professional health culture, the CHR's are much appreciated for their role in interpreting between white and Indian cultures. The field nurses receive practically no formal orientation to Indian culture from Medical Services. The CHR's, mostly by their example and by explanations of various phenomena as the need occurs, fulfill this job for the nurses. By explaining the nurses and community to each other, and by helping people to utilize the resources available to them, the CHR's may be seen as helping Indian people to integrate into Canadian society. Whether this is what the Indian people desire or not is beyond this study. The importance of the question of integration can be understood when Indians, although traditionally very diverse in language, economy, religion, social organization and so on, are looked at from the perspective of their common relationship to the larger society.
The Indian people could be considered a minority, if defined in Wirth's terms as a group of people who because of their physical or cultural characteristics, are singled out from the others in the society in which they live for differential and unequal treatment, and who therefore regard themselves as objects of collective discrimination. The existence of a corresponding dominant group... (p. 34)

Minorities are debarred from certain economic, social and political opportunities, which circumscribes an individual's freedom of choice or self-development. The members of minority groups are held by the majority group to be all alike. They are held in low esteem and in concordance with Cooley's theory of the "looking glass self", members of the group may accept this definition, developing a self-hatred - of the group, of its culture and even of oneself because one is a member of the group. It is the opposite of group identification, wherein a positive desire to identify oneself as a member of the group leads to continued association with the group, creating a community. Many natives feel inferior to non-natives and use this to rationalize dependence on others and their inability to compete in the outside social structure. The personality conflict and stress as a result of this attitude are considerable. Evidence of its existence might be inferred from the statistics on accidents, suicide and crime among Indians. Janis notes that feelings of failure or impotence create resistance to change when an individual is left to himself, though a low self-evaluation also makes an individual more dependent on others and therefore more likely to conform to the norms of the group of which he is a member. This can work both for and against the aims of the CHR, depending on whether a person is a member of groups with aims which conflict or agree with those of the CHR.
One of the frequent consequences of being a member of a minority group is the development of a feeling of alienation. Such characteristics as a lack of knowledge and understanding of events in which a person is engaged, of the feeling that he is essentially powerless and that the outcome of a situation will depend on external forces rather than his own behaviour, are part of the phenomenon of alienation. Other characteristics of alienation are the feelings of isolation from the majority of society and the conflict of norms such that the behaviour of people in the society is not predictable and not sanctioned predictably as in a stable social structure. Alienation is situation-relevant, nor a personality trait. These feelings are deemed to be more prevalent in lower socio-economic groups. Morris et al. found that the more children a mother had, and the more difficulties she experienced reaching clinics, the more socially isolated and powerless she felt. The patients in a hospital who felt most powerless were less able to learn about their disease, showing the relevance of feelings to knowledge and motivation. They also found that individuals who felt powerless and isolated had their feelings of unworthiness reinforced by unsatisfying contacts with the outside world and its institutions. They pointed out that to break the cycle, the barriers in the system must be broken. Out-reaching types of programs, and making contacts between workers and clients satisfying and positively reinforcing for each are necessary, rather than, for example, the worker showing disapproval to clients arriving late for appointments, and receiving non-cooperation in return. This is one area in which CHR's prove to be very valuable: their knowledge of the society and contacts with key people allow them legitimate access to families who remain isolated and withdrawn, even in the small community of a reserve.
They often know the background and dynamics of a family's position, and use this to find ways to patiently break the cycle of alienation and withdrawal, to make the individual's contacts with institutions more satisfying.

A prevailing antipathy to non-Indian standards and cultural traits militates against using the health services which are supplied by white men. The subtle depth of feelings of hostility come out in unexpected ways. One well-educated Metis in Alberta with a responsible job said that she frequently suspected Indians and Metis would deliberately contribute to the failure of a program to "cast another defeat at the foot of the white man" even if they had to fail with it.

At the same time, the permissive nature of Indian child-rearing and the ethic of non-interference make it easy for a person to assume the sick role, leading to the use of illness as a reason for not working or attending school, and the often-heard comment by health personnel that they are too frequently bothered for trivial complaints. Savin notes that people with the most bodily illnesses show the most disturbances of behaviour, and that illness behaviour is often a seeking of help for psychological problems.

The third area of interpretation is that between middle and lower class. Many reserves remain little enclaves of poverty, distinguished by a lack of a viable economic system and personal and social traits which bear marked resemblance to the subculture of poverty: matrifocality, immediate gratification of needs, a present time orientation, lack of formal organization beyond the family and so on. Some of these traits were functional in
Lewis claims that the culture of poverty represents an effort to cope with feelings of hopelessness and despair which arise from the realization of the improbability of achieving success in the larger society's terms. Many of its traits can be viewed as local solutions for problems which are not met by existing institutions because the people are not eligible for them, can't afford them, or are ignorant or suspicious of them. Like any culture, it tends to perpetuate itself.

Many of the traits already mentioned as part of minority patterns overlap with this one. The lack of effective participation in the major institutions of the larger society is central to the culture. These people have a critical attitude towards some of these institutions, dislike the police, and mistrust the government and those in high positions. They are aware of middle-class values, but do not live by them, for they are not always appropriate to their situation of chronic unemployment, little wealth, and absence of reserves of any kind. This is the rationale for focussing on the need to adapt services to people, making them a means of service to people, not a means of control. The CHR can have an important role both in helping people to use services and in encouraging service organizations to modify some aspects of their functioning, though this latter can be usually only in a minor way. The basic operational structure is set by regional and national bureaucracies, so that the nurses, as well as the CHR's have limited flexibility.
However, no-one the author talked to mentioned explicitly class differences between the reserve Indians and the government personnel. There is a strong societal belief in the equality of Canadian society, in its essential "classlessness", so that people may be seen to differ in their income levels certainly, but that basically everyone shares middle-class mores, morals and ideals. Needless to say, if no problem is recognized, no attempts will be made to deal with it. Both CHR's and nurses mentioned the CHR's efforts in interpreting between Indian and white culture, but their role in the other two areas, professional versus lay, and middle versus lower class, was more subtle and largely unarticulated.
CHAPTER VII

CONFLICTS IN THE PROGRAM

In the previous chapters, several conflicts in the work situation of the CHR's were mentioned. These conflicts in the work situation are echoed, and perhaps intensified by, conflicts which are found in the goals and objectives of the program per se. Such conflicts are to be expected in a multi-purpose program. The major directions in which conflicts are settled reveals the actual operating values and objectives, which may be different from the stated ones. In this way, an examination of the immediate objective and job description and functions of the CHR's can provide indicators of the direction of their resolution.

CONFLICTS IN THE OVERALL GOAL

In regard to the overall goal, the aim of improving standards of health and living is presumed to be in agreement with most Indians' goals. However there is an even longer-term unwritten goal which has been downplayed in recent years due to opposition from Indian organizations, which is that of having responsibility for health services to Indians (and other services, such as education) taken over by the provinces, to be provided on the same basis as they are to the remainder of Canadians. The Indian Association of Alberta claims that health care is a treaty right and therefore a federal responsibility. To the extent that Indian communities support the Association, and to the extent that
this program is seen as a federal move in the direction of abdicating responsibility, the communities would oppose it. The author did not perceive that the program was generally seen as a means to that end, but did not specifically seek information on this matter when speaking with employees of the Alberta Indian Association. It could also be at variance with federal employees in Medical Services who might not wish to become part of a provincial service, with a consequent disruption of their positions, work, benefits and so on, or indeed, to lose their positions entirely.

B. CONFLICTS BETWEEN GROUP A SUB-OBJECTIVES

In regard to the first program objective, i.e. of involving local people in health activities, encouraging consumers to active participation in the carrying out of a service can contribute to conflicts between suppliers and consumers. 'Needs' of the community may be perceived and defined quite differently on occasion by health professionals and local consumers, and compromises have to be reached, which may be time-consuming and frustrating. For example, a nurse might have the knowledge and techniques to plan and carry out programs in the community in a minimum of time. Allowing committees to do much of the work, or simply allowing the time which may be required to generate widespread enthusiasm and desire for a program may conflict with the professional worker's need or desire to get a
job done quickly. The trade-off between carrying out a program by
the professional to solve a problem perceived by the professional,
and allowing a program to arise from and be worked out through
community perceptions of need must often be decided in the indivi-
dual situations. Most of the operationalizing of this consumer
involvement is at the volition of the field nurses and is not an
administrative fiat. Moral support for so doing is expressed by
administration, but the effort and time required on the nurse's part may make it not worthwhile, especially if it means a reduction
in the quantifiable services the nurse provides - percentage of
population immunized, numbers seen at prenatal clinics, and so on.

There might be conflicts for the professionals, involving
personality traits and areas of knowledge. CHR's are carrying out
functions after a few months of training while the nurse has had
around five years of education for her job. Field nursing on
reserves requires independent and self-reliant individuals with
reasonably strong and secure personalities. The nurses are set up
in a relatively prestigious job, live in a good house and have a
high standard of living by local standards, but this objective
implies that they should be unobtrusive in their work on the
reserve, and allow Indians to plan and carry out programs in a way
which might be very different from the way the nurse would do it.
It also requires that the nurse let the local people take the credit for a successful program even if she was the prime initiator and a major resource in the program. Difficult for any human being.

Another conflict may arise from the nurses' backgrounds and experience, which may often include little contact with, knowledge of, or even interest in political happenings, community development techniques and consumer involvement in health services. Education in these spheres is not provided to any extent in orientation or continuing education by Medical Services. The nurses have often not worked with auxiliary workers before, but are told only briefly in their own orientation about the objectives of this program and the CHR's role, and are given little preparation (a manual) for orientating beginning CHR's. This is part of a perennial problem for all organizations - hiring only people with sterling qualifications, or hiring people who do not have the ideal preparation and hoping they will pick up the necessary expertise on the job, or else providing them with the education and preparation. All three ways can be expensive in terms of money, manpower and mistakes.

Having communities initiate, plan and carry out programs can also conflict with established rules and policies
and other "givens". Initiation of programs at the local level can be done only in minor ways, since control of funds is at the Regional level, or in the hands of other departments, mainly the Department of Indian Affairs and Northern Development. New programs which don't cost money can be carried out easily enough. And most programs and services provided by Medical Services are statutory, or, eg. policies in some regions to fly pregnant women into hospital one month before birth, etc. They could not easily be discontinued, even if local people, community or workers, wanted to do so.

The administration's objective of making Indians more interested in and aware of their health problems, and therefore leading to demands for more action on them conflicts with the limits on resources in terms of money, time and manpower to meet problems and demands. A community which is politically aroused may become "too active" or actually hostile to government workers, making it difficult to attract white workers to the area. It creates strain for the auxiliary workers as well, who may be disapproved of as 'agents' of the government or of being too much "like the white man".

By having the Band administer the CHR program, Medical Services may have to train Band-selected people of whom they may not approve as good candidates for the job. The CHR must be
functionally accountable to the field nurses, who are responsible to see the auxiliary's work is safe and appropriate, but a certain amount of control is removed from the nurse's hands if the Band is responsible for promotions, hiring, firing, program approval and so on. The Band may define what the worker's functioning is to be quite differently from the nurse's desires. Band control also carries the risk of down-playing the importance of health programs and a consequent lessening of available resources, since native Band administrators are usually primarily concerned with economic development and employment problems on the reserves. Yet one of the ideas behind having the CHR accountable to the Band is to help ensure that the worker does perform in the interests of the community, working on problems the community sees as important - not to be co-opted into the Medical Services way of seeing and doing things. Their primary identification is ideally to be with the community, not with the bureaucracy.

Another risk which is invoked by having "local people" involved (here meaning the auxiliary workers rather than the community) is that the workers will be seen by the community as a "second-class" mode of service, in comparison to the professional nurses and doctors they may desire or be used to.
C. CONFLICTS BETWEEN GROUP B SUB-OBJECTIVES

In regards to the second objective i.e. of helping professional workers to be more effective by providing a link with the local community, several conflicts present themselves. This objective implies that services and programs could be altered and adapted to local conditions, conflicting with administrative need for a certain amount of standardization and routine, so as to facilitate coordination of services, allow newcomers to fit into the system quickly, evaluate services and so on. The problem of resource shortages arises again - alterations require time and knowledge of the local situation. A conflict is possible in the desire to have the auxiliary worker create a favorable environment for the professionals' work, and at the same time be an advocate for their own community, explaining local beliefs, values and customs to the professionals and helping individuals to benefit from the system, not the reverse. Bridging two cultures is difficult. The community may criticize the worker for being "too white", yet if he remains sufficiently in touch with his own people, culturally, socially and economically, he may not always be in agreement with Medical Services goals and programs, and his social and working relations with field personnel especially may be far from smooth. Support from the nurses is crucial to the success of the auxiliary's work, as the brief training course may not equip her
with all the necessary expertise and knowledge. The position of the CHR vis-a-vis the nurse makes it difficult for her to be too critical of the nurse or agency, for she is dependent on the nurse for information, health knowledge, moral support and recommendation for pay raises and continuation in the job. This is another dilemma for Medical Services. The CHR's need to have sufficient education to carry out their jobs, and more education would supposedly make them more effective. There is also the philosophy expressed by Medical Services of encouraging Indians to continue to educate themselves and better their chances for good employment - to realize their potential in whichever way they feel appropriate. However, further education carries the risk of reducing their empathy for or even alienating them from their own community, especially the lower socio-economic groups. Their effectiveness as a link to reaching groups the professionals find hard to reach may be reduced. Are they more valuable as professional workers (and this often means leaving the reserve to work in the cities) or as auxiliary workers on the reserve?

D. CONFLICTS IN THE THIRD OBJECTIVE

As regards to the third objective i.e. of increasing the number of active health workers in the field, a few conflicts are apparent. A larger work force, especially with this category of
worker who has no counterpart in the provincial health services, may make it more difficult to hand Indian health services over to the provinces. As well, increasing personnel and therefore expenditures conflicts with a limited budget. Besides having more field workers, more administrative personnel to educate, co-ordinate, and administrate the program are necessary, conflicting with the belief in decentralization and a desire to place maximum resources in the field at the delivery level, as claimed by Medical Services administrators. The author's impressions of the major directions of resolution of these conflicts and their implications for the future of the program form the basis for the conclusions and recommendations of the next chapter.
CHAPTER VIII
CONCLUSIONS AND RECOMMENDATIONS

A. ANALYSIS OF OBJECTIVES

In analyzing the activities and achievements of the CHR's in the eight chosen reserves, no statistical data were available to measure the concrete achievement of any of the objects laid down for the program. Instead, an impressionistic analysis was done by the author, based on interviews and observations made on the reserves and with Medical Services personnel and other people in contact with the program. It will be obvious that the study has a fundamental weakness, which is the lack of input from the consumer's side. The point of view taken in the evaluation is that of the provider, and the objectives measured are those set up by white middle-class health professionals.

However an impression of the appropriateness of the program objectives to the Indian people can be gained partially from their achievement rating, assuming that those of most interest to CHR's and their communities would be more easily and most often carried out. This agrees with a detailed survey done in the United States where an inventory was made of CHR's functions. They found that the CHR's performed the tasks they considered of highest priority most frequently. The consumer's point of view is glimpsed only, by his participation or not in program activities, and surmised from knowledge of the environment and culture on Indian reserves.

Only the immediate sub-objectives were evaluated. They do not necessarily guarantee achievement of the longer-term sub-objectives, and indeed, in some cases, the author gained the impression that achievement went no further than the immediate sub-objectives. (See p. 75 to p. 82.)
A rating of 1 to 3 was assigned by the author to each sub-objective. The criteria used to assign a rating were: the interest expressed by the CHR in this activity, how often she claimed to carry it out, her feelings as to the results she obtained, and the assessment of the nurses as to the achievements of the CHR's in this function.

A rating of "1" means very little activity in this area, and expressions from the nurses and CHR's that little had been or could be achieved here. A rating of "3" means the most frequently-performed duties and satisfaction expressed as to the results of activity. A rating of "2" is intermediate in amount of activity and impressions of effectiveness.

Below each objective rating, a brief summary of mainly situational variables affecting the outcome are presented. Policy variables will be discussed more fully in a separate section.

1. Rating of Achievement of Sub-Objectives A1-Al2

<table>
<thead>
<tr>
<th>Objective</th>
<th>Rating</th>
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</thead>
<tbody>
<tr>
<td>1. Frenatal care</td>
<td>X</td>
</tr>
<tr>
<td>2. Child immunization</td>
<td>X</td>
</tr>
<tr>
<td>3. Nutrition teaching</td>
<td>X</td>
</tr>
<tr>
<td>4. Dental hygiene</td>
<td>X</td>
</tr>
<tr>
<td>5. Environmental safety</td>
<td>X</td>
</tr>
<tr>
<td>6. Family Planning</td>
<td>X</td>
</tr>
<tr>
<td>7. Exercise promotion</td>
<td>X</td>
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<tr>
<td>8. Alcohol use</td>
<td>X</td>
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<tr>
<td>9. Home nursing</td>
<td>X</td>
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<tr>
<td>10. Support services</td>
<td>X</td>
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<tr>
<td>11. Screening</td>
<td>X</td>
</tr>
<tr>
<td>12. Water sampling</td>
<td>X</td>
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</tbody>
</table>

A high rating was given to activities in the areas of baby immunization, nutrition teaching, environmental hygiene and safety,
home nursing, transportation and other support duties, physical examinations, and water control duties. All these have certain characteristics which make them likely to be more frequently performed and successful than other duties. The CHR's have had experience in many of these activities before joining the CHR program, simply by way of growing up on the reserve and raising their own families there. Their resulting knowledge and confidence would lead to a concentration on such areas. Most are easily-learned duties, requiring no complicated theory or skills, and they are concrete, active functions, not just verbal activities, with visible, quickly-seen results. This makes them more satisfying than some other duties. They are also quite legitimate functions in the eyes of the Indian community, as they are concerned mainly with children and domestic affairs; children in most societies are objects of much attention, especially of women which these CHR workers are. As well, such basic needs as food, water and shelter are large problems on Indian reserves and take priority over many other concerns. They are logically of much concern to CHR's and the community. These also have been the traditional areas of concentration of public health programs, and it can be assumed that the nurses could give the CHR's most support in the areas in which they themselves are most knowledgeable.

Low and medium ratings were given to achievements in the areas of dental hygiene, family planning, exercise programs and alcohol programs. It is likely that dental hygiene and regular exercise are not very important or relevant to Indians, in view of the other problems they face, and so many social and psychological factors are
involved in the regulation of fertility that simply providing the medical supplies and preaching the need for them will not alter the underlying predisposition to use or refuse family planning. Excessive drinking usually involves the men on the reserves more than the women, though of course the results are suffered by all. It may not be considered legitimate by the Band for a female worker to "interfere" in this area, and most CHR's believed the underlying social factors to be complex and beyond their power to affect. They dealt with problems resulting from alcoholic excesses, rather than the drinking itself. Indeed, to improve the level of people's health in these areas of dental hygiene, exercise, alcohol and family planning required much active behaviour change on the part of individuals, and even health professionals cannot be said to always be successful at that. The structural supports which would make such achievements easier (running water in every home, sports facilities and programs, employment for all who wanted it), obviously require much input beyond the scope of the CHR program and Medical Services' power.

This is no different from the response to health education activities in any other community. The structural supports which decrease the demands placed on people (e.g. putting running water into homes) have a greater health impact than service activities which ask for an increase in performance levels (asking people to haul more water and boil it).

It was possible to classify the results of achievements of these sub-objectives by the type of reserve only very loosely. The
impression is that the programs requiring more sophisticated and/or collective approaches (alcohol treatment, family planning, organized child care such as foster or day care) were more often found on big reserves near cities (though still well-defined geographically), where there had been more governmental input and considerable contact between Indians and whites, and on reserves which were economically independent, i.e. not dependent on large government subsidies for their major source of income. These included Kehewin, Morley, Hobbema and Blood Reserves. Maternal-child work and environmental cleanliness programs are slightly less important on these reserves where people have more amenities (housing, water), somewhat higher levels of education, and have had such programs for a long time or at least access to alternative services in nearby cities. This points up the multiplicity of demands which is placed on health service programs and the problem of training health workers appropriately for their work situation.

2. Rating of Achievement of Sub-Objectives A13-A20

<table>
<thead>
<tr>
<th>Objective</th>
<th>Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>13. Health classes in schools</td>
<td>X</td>
</tr>
<tr>
<td>14. Audio-visual aids</td>
<td>X</td>
</tr>
<tr>
<td>15. Utilization of mass media</td>
<td>X</td>
</tr>
<tr>
<td>16. Attendance at Band meeting</td>
<td>X</td>
</tr>
<tr>
<td>17. Group organizations</td>
<td>X</td>
</tr>
<tr>
<td>18. Health committees</td>
<td>X</td>
</tr>
<tr>
<td>19. Organization of special projects</td>
<td>X</td>
</tr>
<tr>
<td>20. Mutual work with other service agencies</td>
<td>X</td>
</tr>
</tbody>
</table>
It is noticeable that in this group there were no high ratings given. The CHR's had a medium rating in attending Band Council meetings; this varied with their opinion of the Council's effectiveness and interest in health. There is evidence that in some Bands, majority rule and elected Councils are considered by many to be non-Indian customs, and they are hostile to this mode of government. In such cases, the CHR may be more effective by by-passing the formal structures. CHR's felt that informal ways of working often aroused less attention and potential opposition. The more formal methods of organizing committees and attending Council meetings are more familiar and accessible to white government personnel, especially if they do not live on the reserves. The CHR's who are part of a whole network of power relationships in the reserve can work effectively behind the scenes and after-hours, especially where the formal reserve leadership is less than dynamic and the community is split into many factions along class, kinship or other lines.

A low rating was given to achievements in health education by the use of mass media, meetings, exhibitions, films and so on, in work with community groups to improve health, work on health committees or involvement in workshops, health education programs, youth camps and like activities.

Health education more often involved passive roles for the CHR's: listening to individually expressed problems and providing instruction if requested, rather than the more aggressive means of meetings and workshops. Mass media such as printed material are not useful if people do not read much, or if they do not gather in groups, to be taught with visual aids. On one reserve where there was a
local newspaper, the CHR used it for notices or articles about health problems, but such facilities were not available on other reserves. The CHR's felt in general that the preparation required to gather groups for organized teaching sessions was excessive, when compared to the results obtained.

Developing indigenous leadership on reserves is a problem for more than the health system, and others have been long involved in looking for ways to allow the Indians a larger share in the decision-making on reserves. Leadership skills are in short supply in any community. Other concerns on the reserves, such as the economic problems, are more important than health, and much of the leaders' time is naturally taken up with them. Health committees have difficulty in attracting active members and the interest of the Chief and Council in their affairs. The fact that most health committees are composed of women and the Chief and Council are usually men may also reduce the committee's power. If the CHR is related or somehow close to the Chief and Council, she may not feel that a committee is so necessary to reaching her ends, and can achieve them through personal influence.

The last activity in this group to be least-performed was that of organizing and conducting workshops, summer camps, youth programs and other group activities. These frequently involved substantial organization, funds, contacts and coordination with other government departments—all rather sophisticated and time-consuming activities. On some reserves too, such affairs were being carried out by a sports director or social committee.
In addition to the use of informal leaders, a high rating was also given to teaching young school children, an area easily-managed by CHR's and one they considered important.

To classify these results by reserve is again only a loose generalization. The larger reserves, which are nearer cities and economically better off, had more overt and aggressive leadership, and more formal group activities and reserve programs. These reserves were the ones where CHR's were active in health committees, Band Council meetings and organizing workshops, ie. the worker had a pre-existing structure to support her. The most northern reserves are generally poorer and have less activity over-all, both in terms of government services and among the Indians themselves. However, some Bands in the north are small enough that formal meetings and meeting-places are not necessary to achieve collective ends, and kinship groups may carry out the same functions as elected Councils.

3. **Rating of Achievement of Sub-Objectives B21-B24**

<table>
<thead>
<tr>
<th>Objective</th>
<th>Rating</th>
</tr>
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<tbody>
<tr>
<td>21. Language interpretation</td>
<td>X</td>
</tr>
<tr>
<td>22. Cultural interpretation</td>
<td>X</td>
</tr>
<tr>
<td>23. Information giving re services</td>
<td>X</td>
</tr>
<tr>
<td>24. Sensitization to personal beliefs and prejudices</td>
<td>X</td>
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</tbody>
</table>

This area of cultural bridging was given a uniformly high rating by CHR's, nurses and Medical Services personnel. The matter of interpreting both language and culture would be important to nurses
because they usually have a great need of help in this area, to reduce the obstacles they face in carrying out their duties. Medical Services nurses know they will be working closely with Indian people and presumably some have joined the service with an interest in learning about another culture and adapting their work to it; advice and help from the CHR is frequently solicited and much appreciated.

It is also an area where the CHR's knowledge is superior to that of the nurse and this makes it a function where she can feel important and be important. It is also necessary for the CHR's own satisfaction to interpret carefully between the community and nurses, as she is the bridge between the two and wants to get along with both sides. Both nurses and CHR's have a great need for this function to be performed well and frequently.

The help of the CHR in using resources (mainly government services on or outside the reserve) is frequently asked for by Indians. The CHR may be a good alternative to personally facing a person from another culture perceived as hostile, having great power, or any other characteristic attributed to the white man, or she may be simply a good and accessible source of information due to her contacts. Many Indians have little knowledge or experience of the complicated structure of society off the reserves, and thus cannot use various resources and services, or are fearful of so doing.

Probably these functions of bridging are more important on the most northerly and isolated reserves, where Indians have had less contact with white society, are less educated and speak their own language better than English. However, the problems of social and cultural distance exist on all reserves and the linking role of the CHR is invariably important.
4. Discussion

A logic emerges from this rough analysis of achievements. The areas in which the CHR's function most often and effectively seem to be three: 1) areas of most concern to the community and CHR's (and sometimes Medical Services as well); 2) areas where the CHR's have the most knowledge and experience before their course; and 3) areas where they feel their personal resources are most effectively used, and thus gain the most satisfaction from. Those which clash with the Band's way of accomplishing things, the local power structure, the role of women, the priorities of the community, or which are beyond their financial and managerial resources, are performed less often. What dampening effect the nurses had on the CHR's proclivities can only be guessed at, but it is probably quite strong in some situations. If the nurses had less control over the CHR's, their functioning might conceivably be quite different.

B. POLICY CONSIDERATIONS: COORDINATION AND ISOLATION

Policy considerations will be considered in some detail, as they are more easily controlled or manipulated than many of the situational variables affecting the program, as well as being important guides to the administrative decisions which follow upon policy.

The lack of a clear policy on functional roles seen in the CHR program and in Medical Services is partially an outcome of the continuing changes and uncertainties in over-all government policies on Indians and on regional development.

At the bottom of the conflict between Indians and whites is the struggle for power. With roots in the conquest of North America by Europeans, and development affected by the growth of
humanistic philosophies over three centuries, the attempts to alter the amount of control held by various factions are seen in such phenomena as the growth of Indian organizations and the idea of community participation in programs which affect their welfare. What social development and organization theory both are now recognizing is that community development or participatory management does not occur just by asking people to discuss their conflicts face-to-face, thus involving everyone in a decision amicably agreed upon by all. Power systems have structural elements which must be examined systematically for their effects on people and programs, and structural elements built into them which put control where it is deemed desirable, rather than depending on individual personalities for the desired ends. These structural elements are most obvious in the vertical relationships within an organization—the work structure, the technology. But the horizontal relationships an organization has with other organizations which enable it to coordinate and cooperate with them are also determinants of outcomes and effectiveness, the power of an organization. This is one reason for emphasizing the organizational isolation of the reserves, health services and the CHR program from institutional links which would alter their functioning so much. The importance of internal factors has been exaggerated to the neglect of the external institutions which figure greatly in the development of Indian communities.

In another manifestation of the power struggles, public policy recommendations have been variously sensitive to the implications of cultural dualism, that is, the persistence of traditional
Indian culture or some form of transitional culture, separate from the dominant white culture. This is complicated by the various degrees of acculturation which Indians have undergone. Indians living in or near cities are considered to be generally more assimilated to the dominant culture than are Indians on isolated reserves, making standardized programs more or less appropriate. There is some evidence that those people who grow up in an integrated culture, even if it is a small minority, have a healthier ego and are able to fit themselves into the dominant culture with less psychological stress and loss of identity. Though this may be accepted as true in Canada now, the translation of this belief into policy and programs is very difficult. The oscillations between assimilation, integration and separation which go on make the field in which the Indian health service operates unstable and poorly defined; consequently the role of MS in the CHR program in "Indian policy" is uncertain.

The isolation of Indians culturally is echoed politically. Since Indian reserves are managed by one federal government department, they tend to be isolated from provincial government programs, as well as from any regional development programs which would integrate provincial and/or federal departments in the comprehensive development of a region. Health is an acknowledged partner in development, though it must be admitted that the effects of development on health have been more studied than the opposite case. But the lack of a clear and coordinated policy at the top of either government or Indian organizations for the development of reserves alone or as parts of regions is echoed by uncertainty and isolation at the bottom. The isolation of reserves from wider developments and of health services from other government services is repeated for the CHR program, which seems to be an insignificant and awkwardly-placed
It is interesting to note that although CHR programs exist in each province and all over the United States, the author heard of little active collaboration between the administrators and teachers of such programs, in terms of meetings, information and literature-sharing, and such like. In fact, one CHR trainer's attempts to share ideas, information, literature, teaching aids and so on produced so little feedback and reciprocity from other CHR trainers, that he refused any longer to make such attempts.

Excluding health, the Department of Indian Affairs handles all aspects of Indian communities, including community development. The federal government has expressed its wish that the Indian health service be taken over by the provinces, but at this time the program is isolated from the provincial health system as well as the mainstream of Indian Affairs activities. The CHR's must work across these gaps, as some of their functions are not really the responsibility of Medical Services. For example, the Department of Indian Affairs is responsible for well-digging, and often arranges for it to be done through the provincial services, yet Medical Services feels it is a health responsibility to ensure that people have sufficient and safe water to drink. Some functions are carried out separately by both departments, eg. auto safety campaigns. The CHR's concern for the mental health of the community may mean that she has to contact Indian Affairs and/or the correct provincial department for funds for sports activities. The result of such difficulties is the narrowing of the scope of her activities to more manageable individual nursing contacts.

If the CHR program itself is poorly integrated into the general
scheme of things, the workers too can be easily isolated from sharing in the activities of Medical Services, in terms of access to information outside what the nurses choose to give. Some alleviation is provided by their attendance at the annual conference, but there is an active provincial health service with its educational programs surrounding all of the reserves, which is not made use of.

The province of Alberta also runs a similar program to train auxiliary public health workers for areas of the province with large Metis populations, but contact between the two programs seems to be minimal, and they differ widely in selection, training, duties and other aspects. With Medical Services itself, the CHR's are now responsible to the field nurses, but there are plans to create positions of CHR supervisors to advise at Medical Services headquarters and give support to CHR's in the field, which will provide a mode of career advancement as well as support separate from that given by nurses.

The nurses lack experience in community development and the use of auxiliary personnel, which means that they and the CHR's carve out large parts of their roles for themselves in each reserve situation. This flexibility is a great advantage when the reserves differ so much, but the result is often that the CHR acts as a nurse's helper, quite dependent for any job enlargement on her. This will be enlarged upon in the following section on role conflict.

It is important that the nurse wants an auxiliary, and does not mind sharing some of the responsibility and power of the health service on the reserve. It is also important that Medical Services wants a strong Indian involvement in health care and strong health involvement
in the over-all development of the Indian people. The short-sighted approaches seen in the past to the "Indian problem" in Canada need to be replaced by much more comprehensive planning and programming, which is a problem of much greater scope than the roles of Medical Services, DIAND or the Indian Associations themselves. It involves the political system in Canada as a whole, and the willingness of the majority population to seek out and carry out the policies required.

C. FURTHER POLICY CONSIDERATIONS--ROLE CONFLICT

One very noticeable element in this program is the basic division between those workers who acted more as community developers, and those whose emphasis was in more traditional public health nursing roles, often acting as assistants to the nurses. Both roles are described by the program objectives, but the major emphasis at least in the beginning of the program was intended to be on the former.³

This study found that in actuality most of the workers' and nurses' emphases were on traditional public health nursing activities, i.e. the concentration on one-to-one curative, preventive and educational service. While these are important duties, and go some way to meeting community demands, there seems to be little awareness of how these could be used as a lever to community development. It may be that the personality traits required for effective one-to-one health work, where the worker cares for and counsels a mother, an adolescent or an elderly client, are incompatible with the traits required for effective community and group work, e.g. teaching in schools, arousing public demand for programs, or encouraging the formation of committees. Even if not incompatible, they may be very difficult to find combined in one person, and
perhaps should not be expected, unless considerable training is given to develop the workers' skills in both areas.

The activities of public health nursing which are traditional are often considered by Indian communities to be the most important duties of the health service, especially where reserves are isolated from other health services. Such work is also likely more satisfying to most nurses and CHR's. They have been trained in them and results are sooner seen than in more nebulous and slow-moving committee work. Recognition from one's employing agency follows visible, quantified results, and this is a powerful motivating force. Other pressures arise from the Band, who have an idea of how they want the nurse to function. On one reserve, a Band disapproved of nurses restricting clinic hours in favor of home-visiting and preventive work. The CHR is obviously subject to the nurse's ideas of what and how functions will be carried out, and thus must accommodate her own proclivities to the nurse and the Band both.

Support is also given to health workers not just by yea- or nay-saying, but by education and training as well. Medical Services in its orientation program, continuing education and conferences could imply their support or not by the existence or lack of instruction in community development. The salience of politics to health matters is largely ignored in professional health training. Most nurses would have been educated in biological-physiological theories of disease, rather than ecological concepts of health. Indeed the interrelationships between health and general economic and social development are complex and poorly understood. Medical Services professes the need for community development approaches, but has no community developers or anthropologists on staff.
or as advisers, and gives no training or orientation to its own staff, especially field nurses, in cultural sensitivity or community development.

A health worker's belief that most of the causes of poor health on the reserve had their roots in the economic and political situation of the Indians, matters outside the strict purview of Medical Services, could raise some conflicts for her. On the one hand her training and outlined job functions equip and require her to function independently and decisively in the usual public health mold, while a developmental approach would mean her activities focus also on community organization and political action programs, demonstrating a willingness to go along with and encourage the local leadership priorities, taking a less prominent role herself and seeing the indirect benefits to health which can be gained. So far, no systematic evaluation of the growth of indigenous leadership on the reserves has been carried out, though this has been mentioned as a major result of a similar program in the U.S., i.e. an increase of community identity and cooperation, and awareness of its own capabilities. Formal recognition of the difficulties of this process and a description of the roles of the CHR and nurse in it is not so far forthcoming from Medical Services.

The encouragement of local initiative carries with the possibility of confrontation and resistance which may be viewed as simply making the health service's job more frustrating, or alternatively as a sign of healthy dissolution of dependency and passivity, and an increase of organizational skills and sense of pride. An administrator in Medical Services in Edmonton mentioned that the nurses who became "advocates" for the Indians and encouraged them to conflict with Medical Services if necessary often created the most problems for the bureaucracy in Edmonton, but he considered that they were performing a very valuable
function and were worth the trouble.  

It is to be hoped that similar activity on the part of the CHR is recognized and encouraged. The author gained a very limited impression of the CHR's activity in social advocacy, and it seemed to involve a very diplomatic covert mode of expression, and little overt conflict between field staff and CHR's. Usually it amounted to explaining or defending a client's behaviour to a nurse and sometimes standing up for clients against the Band Council.

Role-conflict could develop to the point where the CHR could be torn between demands of the nurse, the community and the Band Council, and the strength of the pressures coming from each source will decide the CHR's responses differently. Some of the workers felt the conflicting demands more keenly than others: one CHR, for example who had to work with a Band Council she thought partisan and ineffective, and nurses too new and too young to be able to help her, and thus she felt she had to champion the members of the community alone. Another CHR felt that she, the nurses and the Band Council had essentially harmonizing goals and conflicts were rare.

For any government bureaucracy, including Medical Services, the temptation to dispense with community involvement is very great. In health, it is claimed to be a vital preliminary to linking the health service with wider community goals. Theoretically, community involvement should be easier to obtain at this stage of the program, with the spread of the "Red Power" movement in Canada. This movement is trying to help Indians maintain a sense of integrity and community identity, to help build up native leadership and pride.  One of the results of its efforts has been a move by some Bands to take control of most of the reserve affairs, which
includes the hiring of people as Band employees to work on the reserve, rather than as government employees. The idea of the community administering this program is regarded favorably by the 1973 Task Force Report on Community Health Workers as a means to community involvement, but makes no mention that this is a vehicle to further community development. It is also questionable that having the Band Council run such programs automatically raises the level of total community participation in them.

Not all Medical Services administrators and nurses agree with the idea of Indian administration of the CHR's, and several of the Band Councils had refused the responsibility of administering it, though all had helped with the selection of the CHR. One administrator in Medical Services felt that even though CHR's hired by the Band could more easily fulfill the social advocacy role, if they had the firm backing of an administrator responsible for them in regional headquarters, i.e. they had their own advocate, they could stand up for their own people when necessary, even if hired by Medical Services. He felt that Band Councils generally do not know enough about health matters to evaluate a CHR's performance. There is also the real risk that health would be a very low priority in the face of all the other Bank problems, and the CHR's responsible to Medical Services would have more resources available to them, which in itself would help to elicit Band cooperation. The CHR's, concerned about job benefits and stability, generally wish to be public servants. In the United States, where such workers are hired by the tribes, a frequent problem is the firing of the old worker and the nomination of a new person for training with each turn-over of tribal
government, which interfered greatly with continuity of care given to families. It appears the problem has been resolved in Alberta by the CHR's formally asking to remain on a contract basis with Medical Services, instead of becoming Band employees, so that the original objective has been frustrated in this province.

Another very striking element in the role of CHR's is the absence of activities to do with problems with alcohol. Medical Services seems notably reluctant to deal with this area, and most alcohol programs are initiated and managed by provincial alcohol foundations, with the cooperation of the Bands and occasional involvement of nurses and CHR's. Alcohol is usually listed by anyone involved with Indians as their major problem, yet the ability to deal with it is markedly restricted in Medical Services, both in terms of prevention and amelioration of its effects. It is a complex social and mental health problem, granted, but ignoring its large presence and not encouraging health workers to study about it or deal with it actively does not give credibility to Medical Services' wish to effectively bring the level of health of Indians up to national levels.

Thus, there are policy decisions regarding the role of Medical Services in helping Indian communities to develop, the role of the CHR program in Medical Services, the role of the Indian community in the program, and the role of the worker herself in the reserve, which can be affected by conscious and unconscious policy decisions. Recommendations for the direction of policy in these areas are offered below.
D. RECOMMENDATIONS FOR THE CHR PROGRAM

One of the themes of this thesis is that excess emphasis has been laid on the factors internal to Indian communities and programs which affect functioning, rather than examining carefully the factors external to it—the political, social, economic barriers to improvement of the life of Indians. That is why the recommendations given here for the CHR program emphasize policy in regards to external relationships.

The very small size of the program, the fact that it has never had the initially recommended quota of CHR workers, indicates a lingering hesitancy about the program, a disbelief in its worth. It cannot be considered to have been effective in Alberta, to have had a significant impact, because it has never really been tried. There is nowhere near the level of one CHR worker for every 600 Indian people in Alberta (the originally described ratio). The administrative structures which would help to bring that about, such as a permanent educator/supervisor for CHR's and regular training programs with opportunities for advancement in skills and position levels, do not exist. Selection of and training programs for CHR's seem to be haphazard and ad hoc, using resources internal to Medical Services, and not involving the larger community which could help—universities, vocational colleges, DIAND, provincial programs for health aides. Several suggestions arise from this situation.

1. Go or No-Go?

A definite commitment needs to be made. If Medical Services feels the program is worthwhile, it should at least be brought up to the strength of one worker per 600 natives, with on-going budgetary support for
strong training programs and back-up by orienting nurses to the role of CHR's, strong Indian representation at all levels of decision-making, structures to coordinate this program with other agencies, and other methods described in recommendations below. The belief of this author is that the health of Indians will only be improved when large numbers of Indians are themselves providing health care, both in direct services and administration of services. The CHR program is one base on which to build, but it needs far more resources put into it, a much higher status, and some alteration in policy.

2. What is "Responsibility"?

A commitment needs to be made as to the role of this program in Medical Services' stated desire to have Indians take more "responsibility" for their health. This occurs in two decisions. One is whether this program will have structures which act as means to actively encourage native people to become health professionals, or whether CHR's are to remain as sub-professionals with expansion and diversification of their duties dependent mainly on the personalities of the field nurse and the CHR. The second role-decision is whether the program is to be the responsibility of the Indian people, totally or partially.

Because of the great variety of reserves and the needs of the people in them, the maximum program flexibility needs to be maintained. Thus, the sub-professional role should be preserved and valued, while making it a vehicle to professional health careers. On northern reserves, especially where educational levels are low, it is difficult to find candidates who will be able to move on to professional training, and means of maximizing their skills appropriate to their situation need to
be explored. This of course means the various levels of CHR's: beginner, middle, senior, with recognition for experience and further education, be maintained. Some suggestions for this are given below in recommendations on career structure and training. On reserves where Indians wish to work as professionals, the experiences and training gained as a CHR need to be given proper credit. Medical Services could set up methods of making health careers more accessible to natives as has happened with teacher-training programs in Alberta, and in the United States, where members of ethnic minorities are given preferential status in universities. Entrance requirements can be reduced, special tutoring arrangements set up, more flexible training programs arranged which allow people to return home between sessions, and credit given for previous non-professional experience. The professional nursing, nursing aide and social worker associations must also be involved in devising a plan for education and for career mobility—either vertical or horizontal—between CHR's, the provincial Community Health Associates, nursing aides, nurses, mental health nurses, social workers and aides, and so on. This has not so far been seen as a responsibility of Medical Services, but neither educational departments nor DIAND have taken it on, and Medical Services should take the initiative to fill this great gap.

Regarding the responsibility for administration of the program, Medical Services has stated that it wished the Bands to manage it themselves. There are arguments for and against this. One pro is that accusations that the CHR's "work for the white man" would diminish, and a con is that continuity of care could suffer as successive Band
administrations changed the CHR they administer. This author believes that active participation of the Indian community in health programs will come only when they feel the program is theirs to direct and maintain.

The program is not "theirs" when Band funds are given by DIAND or Medical Services, and the roles and objectives for the program set by Medical Services, the training programs set and run by them, the supervision done by them, and withdrawal of budgetary support controlled by them or DIAND. This harks back to the question raised in Chapter VI as to whether a program should be in accord with the client's or the professional's definition of "needs", or a combination of both.

Some improvement can be made by asking the Bands to decide what their major health problems are, if they want a CHR, and what services they would wish CHR to provide. They should then select the person capable of being trained to meet their requirements. They should also be responsible for the supervision of these workers, and ask the technical advice of the professional workers most appropriate to their CHR's tasks—the nurse, the social worker, the DIAND agent, alcohol treatment workers. This is admittedly not always feasible when the Band wishes to have a CHR but has little expertise in or time for health, or indicates its desire to have the program administered by MS. But Medical Services should regularly propose to the Band that it take over administration of the program and MS should play a technical advisory role only to help the Band decide their health needs, set objectives for and evaluate the program. Some safeguards against the problem of political hirings and firings of CHR's could be built
into the CHR's contract with the Band, and sufficient funds must be
given to the Band that the worker's remuneration is reasonably close
to public service levels, i.e. to the levels which CHR's now working
receive.

Indian involvement in decision-making for the program needs to come
at all levels. The Alberta Indian Association should work with Medical
Services on the policy decisions mentioned in this chapter, and set the
basic orientation and objectives of the program. It could be involved
in informing Bands about this program and initiating requests from them
for it to Medical Services, rather than Medical Services being the sole
source of information on it to the Bands. The Association could also
be involved in evaluation of the program on a regular basis, with
Medical Services' help, and assist with the problems which might arise
over employee discipline, firings, promotions, further training and
so on. The CHR supervisor/coordinator for each region (two in Alberta)
might well be an employee of the Indian Association, rather than of
Medical Services, to increase the knowledge and role of the Association
in health services to Indians for one thing, and to facilitate the
program being managed more and more by Indian hands.

3. What Should the CHR be Doing?

The wide variety of functions which are being carried out by
CHR's or which are possible to her should be set up in clear job
descriptions, and the Band and she should decide in which areas she
will function. So far, CHR's are working in the areas of public health
nursing and/or community development, with almost no involvement in
alcohol problems.
If Medical Services has a deliberate policy to be non-active in the problems with alcohol, it should be clearly stated so. Nurses and CHR's should then be given job descriptions which clearly define the difference between prevention of alcoholism and the treatment of results of alcoholic excess, and told where their duties lie. It must be said that this is a head-in-the-sand approach, as alcohol is definitely a major problem on most reserves, and Medical Services cannot ignore its effects. A training and supervisory structure which allows and encourages CHR's to deal with alcohol is needed. This is probably most easily achieved by asking the participation of alcohol foundations or groups such as Alcoholics Anonymous to allow CHR's to participate in training programs and use the expertise of professional alcohol workers. An "apprentice" system could be set up whereby the CHR's spend a definite amount of time with the alcohol workers, using a curriculum with definite learning tasks and assignments for the training period, and then having clear and responsible tasks afterwards in collaboration with the other alcohol workers.

Essentially the same system is recommended for those workers who wish to function mainly in other modes. Those who want to work in nursing services will of course receive most of their training and support from nurses, and be evaluated by her and the Band. Those who wish to work in developing group activity on the reserves should have close working relationships with DIAND agents, especially community developers.

As the training component is basic to the roles taken by CHR's and a major input to the success of the CHR program, it is discussed in some detail below.
4. **The Training Required**

Training for the CHR program occurs in two areas: for the CHR's themselves, and for the people who support them technically, mainly Medical Services.

Because the program is so small and new candidates few, it is difficult to mount formal and regular educational programs, especially to cope with the diversified roles of the CHR's suggested above. However, if Medical Services makes use of resources outside its own organization, and sets up educational guides to those doing on-the-job training for CHR's, the problem can be partially solved. For example, the university, to this point uninvolved, could lend pedagogic expertise to devise curricula, teaching guides and self-instructional manuals for the various task areas in which CHR's work, as well as help devise and teach formal programs. A program of information exchange with the U.S. Indian Health Service would be valuable, as they have a considerable number of training programs set up and have tried various approaches with instructing CHR's. The provincial health aide training programs at the vocational colleges could be open to qualified CHR's or candidate-CHR's, as could the informal workshops and meetings of various agencies, especially the provincial health units and social work agencies. The problem of coordination between federal reserve services and adjacent provincial services is a difficult political one, but certainly informal collaboration should be possible, and a structure set up by which CHR's and provincial health aides have access to educational opportunities in both Medical Services and provincial agencies. A health educator at regional level would be valuable in
linking CHR's up with such resources. Some thought should be given at this time to developing similar selection criteria, training programs and career patterns between the federal and provincial auxiliary programs.

Especially for additional training, experiments might be made with clustering workers by reserves, e.g. those from large and developed reserves versus those from small and less developed (according to levels of education, employment levels, collective activities, other services on the reserve, and such criteria), so that more appropriate material can be offered to trainees. There is no policy reason also that a training program cannot be for CHR's from many regions if it caters to an interest of only a few workers per region; probably travelling costs would restrict this. It does require close collaboration from all educators and supervisors involved with CHR's in all the regions.

In spite of the widely divergent roles of CHR's, some core elements are seen in their functions, and basic training can be given for all in these task areas. According to this analysis and to others done in the U.S., most CHR's function in physical health care activities, maternal-child health, environmental health, patient care, homemaking services, transportation, coordination and liaison activities. A few work with groups and some do "mass" health education; some are in alcohol programs and mental health. Thus the core training should involve home nursing, child and home management, environmental concerns and interpersonal helping skills, and, if necessary, driving lessons. Later on, more specialized instruction in areas of special interest
or need of CHR's should be made available to them. A determined effort in all such training has to be made to not subsume the workers into the value systems of the trainers (who will be mostly whites, though Indians should be used when available), but to help them articulate their own values and maintain their identity with their clients. Likely, the Indian Association could give advice and do some training here. The important thing is that such training structures be built into the program, to reduce the almost total dependence of the CHR on the nurse for diversification of skills and duties.

Because it is foreseen that CHR's will continue to have much contact with the nurses, structures to support the nurses in this new role need to be included. One is orientation for nurses to the culture on the reserves, using anthropologists and Indian representatives. Another is the introduction to community development processes, and practice in carrying out some of the techniques, or at least in not hindering others as they carry them out. The fact that conflict is inherent in the process of community development and social advocacy should be openly expressed and the nurses and CHR's helped to deal with it with as much objective knowledge and understanding as possible. Lastly, the nurses need careful guidance in the training, development and functions of CHR's. They should learn how to allow the CHR to make maximum use of her talents and help her to diversify her skills, in the initial nursing orientation, through teaching guides, and by continued supervision. This is a point on which to evaluate the nurses as much as on any of the traditional nursing duties--the development
of the CHR's with whom she is working, as measured by a diversification in their duties and increase in skills.

5. The Place of Evaluation

Evaluation is also part of the process of role-definition of the CHR program. If administrators are still unsure of the worth of the program, then some evaluation should be carried out to help decide whether it should be expanded or contracted or terminated. On the premise that it should be, and will be, expanded, then both routine and special evaluation efforts need to be made.

Ongoing evaluation, or monitoring, would be a help to setting up training programs. The services carried out by CHR's should at least be compiled regularly by region, and supplemented by interviews of clients and observations of the CHR in the field, as input to making minor modifications in selection and training processes, and administration of the program.

A more thorough-going evaluation would involve selecting reserves which do not have CHR's and monitoring certain variables for a year before a CHR is placed there, to establish a baseline. The variables could include the areas in which she would likely function, plus the changes in the reserve's environment which will affect the program, such as the services provided to the reserve, changes in its economy, changes in transportation facilities, extensive migration, and so on. The variables measured as outcomes of her work could include such variables as the extent to which health and social services are used by the community, changes in the levels of environmental cleanliness,
incidence of a few selected diseases and accidents and violence, changes in number and character of voluntary groups, and changes in the Band budget for health.

Where programs are considered "successful", a thorough study could be made to determine which are the elements common to successful programs, so that attempts can be made to include those variables in other reserves. Along with the monitoring of successful programs, modifications can be made in approaches in other reserves, to see if such changes make a difference in clearly identified outcome variables.

E. The Future

Provincial or federal government's plans for the administration of treaty Indians are not clear. Nor is it clear what plans are for area development in the province, and what share if any the reserves will have in them. The answers to general questions of Indian development are basic to the role of Medical Services, for they will require a continuing re-thinking of objectives, programs and functions. What can be said is that at least the health service should try not to obstruct or disrupt the efforts of the native people to maintain or develop an integrated culture for themselves. The key requirement on the part of the health service is flexibility in this changing context.

One of the great strengths of the CHR program is its

* The World Health Organization is currently conducting a world-wide study in community development programs, to try to determine the necessary and sufficient causes of community development. Health is considered both an input and a result of community development processes. (Personal communication, Dr. H. Strudwick, Division of Family Health, WHO, 28 Oct., 1976)
flexibility, its ability to be appropriate to local situations.

It is important, for example, that selection of CHR's continue to be done by the Band, after careful explanation by Medical Services or the Indian Association of the roles and expectations for workers.

If the Indian health service and this program eventually become the responsibility of the province, the scope and the circumstances under which the CHR's will be operating will widen. There are indications that this may indeed be what will happen: the scanty back-up in terms of administrative supports, education and evaluation, coordination with other federal departments and with the province may be signs that Medical Services does not want to put great efforts into expanding and strengthening the program if these efforts will be made superfluous by later events. If the province does take over, the advantages of having the large provincial health services' resources available to the program are great. As well, the possibility of closer integration with provincial development programs exists, along with the expansion of the program off the reserve. The CHR's could be an appropriate adjunct to the use of native social worker aides. The rate of Indian migration off the reserves is increasing, and selecting CHR's from those who made the adjustment to city life to work among Indians in the city could help to alleviate some of the problems experienced by Indians in the cities.

The broadened areas of functioning of the CHR's will require concomitant changes in training and supervision. The larger resources of the provincial health service could manage this, but the
obvious danger is in the pressure to conform to the rigidities of large bureaucracies. The program must not be swallowed up; it must maintain a small but separate identity to cope with the separate needs of the native part of the population.
LITERATURE CITED

INTRODUCTION


7. Ibid.

8. Ibid.


15. Ibid.


**CHAPTER I**


**CHAPTER II**


cont'd...


5. Ibid., p. 492.


9. Ibid., p. 10.


CHAPTER III


24. Ibid., p. 23.

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34. quoted in W. J. Wacko, "Indian Alcohol," p. 6.


CHAPTER IV


5. Ethel G. Martens, "Health Education and Community Development."

6. Interview with Dr. A. Shedden, June 24, 1975.

7. Interview with Dr. A. Shedden, June 24, 1975.

CHAPTER V


cont'd...


CHAPTER VI


cont'd...


9. Ibid.


16. Ibid.


CHAPTER VII

1. Interview with Mr. C. Brooks, August 27, 1975.

2. Interview with Dr. Shedden, June 24, 1975.

CHAPTER VIII

cont'd...


5. Interview with Dr. Kirkbride, September 2, 1975.


7. Interview with Mr. C. Brooks, August 27, 1975.


**OTHER LITERATURE CONSULTED**


cont'd....


APPENDIX I: FIELD VISITS TO COMMUNITY HEALTH REPRESENTATIVES ON FEDERAL INDIAN RESERVES IN ALBERTA

1. May 14-15, 1975
   Pigeon Lake Reserve, Hobbema Health Unit, Mrs. Samson, CHR.

2. June 3-6, 1975

3. June 5, 1975
   Chipewyan Lake, Mrs. Stella Noskiye, Family Health Aide.

4. June 10-13, 1975
   Assumption, Hay Lakes Reserve, Mrs. Regina Pasion, CHR, and Valerie Beynon, Public Health Nurse.

5. July 19, 1975
   Morley, Stoney Indian Reserve, Mrs. Emily Wesley, CHR.

6. July 24-25, 1975
   Bonneyville, Kehewin Indian Reserve, Mrs. Florence Youngchief, CHR, and Mrs. Ida Sansom, Public Health Nurse.

7. July 30, 1975
   Lac La Biche, Beaver Lake Reserve and Heart Lake Reserve, Miss Louise Frenchman, CHR.

8. August 21-22, 1975
   Cardston-Standoff, Blood Indian Reserve, Mrs. Nellie Tailfeathers, CHR, and Miss Nora Brewer, CHR, and Mrs. J. Hinman, Public Health Nurse.
APPENDIX II: INTERVIEWS CONDUCTED IN THE COURSE OF THE STUDY


2. June 18, 1975 David A. Rosner, Regional Health Educator, Medical Services Branch, Winnipeg, Manitoba.

3. June 27, 1975 Dr. A. Shedden, Zone Director, Southern Alberta Zone, Medical Services Branch, Edmonton, Alberta.

4. July 8, 1975 Ms. Marion Iverson, teacher at Alberta Vocational College, Community Health Associate Program, Lac La Biche.

5. July 16-17, 1975 Mrs. Rosalee Desjarlais, Community Health Associate, Grand Centre Health Unit, Grand Centre, Alberta.

6. July 16-17, 1975 Mrs. Laura Collins, Community Health Associate, Elizabeth Metis Colony, near Grand Centre.


10. July 28, 1975 Dr. John Read, Professor of Pediatrics, University of Calgary, Faculty of Medicine, initiator of the Health Centre on Morley Reserve.

11. August 27, 1975 Mr. Charles Brooks, Regional Health Educator, Medical Services Branch, Regina, Saskatchewan.

12. September 2, 1975 Dr. Kirkbride, Regional Director, Prairie Region, Medical Services, Edmonton, Alberta.
APPENDIX III: JOB DESCRIPTION AND SPECIFICATION REPORT FOR CHR'S
(from undated mimeograph of Dept. of National Health and Welfare)

1. Job Summary

Under the general supervision of the Nurse In Charge provides a variety of health care services specific to community needs; demonstrates and teaches community and family health care, sanitation and hygiene; teaches or provides home nursing care to the sick, aged or infirm; interprets federal and provincial health programs and services to the native people; organizes new groups or works with existing community groups to ameliorate the community's health; prepares posters, displays and other audio-visual aids suitable for the community; acts as an interpreter for health professionals and other government officials; plans and organizes own work and carries out duties with a minimum of supervision; performs other related duties.

2. Job Duties

1) Provides consultation, advice and assistance to individuals and families on health matters and makes appropriate referrals when necessary (45% of time)

- by making home visits to prenatales, mothers with infants and young children and other families in the community in order to teach and assist in the provision of safe nurture and health care i.e. diet, budgeting, nutrition, family planning, sanitation, dental health, alcohol abuse etc.

- by visiting the sick, aged or infirm to teach and/or provide home nursing care e.g. gives bed baths, changes dressings, and to make referrals to health professionals and other agencies

- by assisting the nurse or doctor to obtain personal health history data at clinics and in home visits

- by measuring weights and heights, temperatures, pulses; gross vision screening; taking and dispatching sputum specimens, throat swabs, stool specimens; demonstrating personal hygiene practices and basic home nursing procedures; reading Mantoux tests; or other appropriate tests or measurements.

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(....APPENDIX III continued)

- by taking and recording water samples for analysis and taking appropriate action on results of such tests e.g. advising client to purify water, advising local administration to dig new wells

- by assisting families to plan nutritious meals and how to budget income to meet daily food requirements

- by assisting in prenatal, maternal, well-baby, child care, dental and other health clinics by doing patient education especially in the local and native dialect; by interpreting; by acting as receptionist etc.

- by making home visits to introduce new field staff to members of the community and to orient field staff and visitors to the community to local customs and mores

- by advising individuals and families regarding available health resources or resources of DIAND, RCMP, Native Organizations or other agencies.

2) Assists the community and groups within the community to improve their health status (40% of time)

- by working with community leaders, other community workers and government officials to resolve problems affecting the health of the community

- by regular attendance at band and chief and council meetings to recommend needed local improvements such as garbage collection systems, individual and community water supply, housing, recreational facilities etc.

- by organizing new groups (e.g. health committees) or working with existing community groups to ameliorate the community's health

- by taking an active role on Health Committees and in this context drawing up budgets, securing funding from the Band, planning expenditures including activities such as supervising garbage collectors, water delivery man, housekeeping aides or others employed by the Health Committee

- by organizing, planning and conducting workshops, short courses, continuing health education programs, youth summer programs and camps and securing funding for these programs

- by teaching health classes in federal schools at least once per month especially in the local native language when necessary

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by utilizing available mass media to disseminate health information such as researching and writing news releases for native press and radio

- by developing and producing posters and displays, 35mm slide series etc.

- by selecting, scheduling and showing films, slides, filmstrips, videotapes etc. in health teaching programs

- by explaining and assisting the people of the community to understand and make proper use of available health services e.g. well-baby clinic, treatment clinic, doctor's clinic, dentist's clinic etc.

- by advising health care personnel and other visiting health professionals on culture tradition and way of life and helping to improve two-way communication.

3) Performs other duties such as (15% of time)

- keeping records of daily activities and submitting monthly reports to the nurse in charge

- attending regular field staff conferences and other recommended in-service or continuing education programs

- providing her own transportation to ensure mobility as required within the community being served

- acting as interpreter when necessary by accompanying doctors, nurses and other field staff in visits to Indian homes as required, to translate conversation into the local dialect and into English.