DOCUMENT RESUME

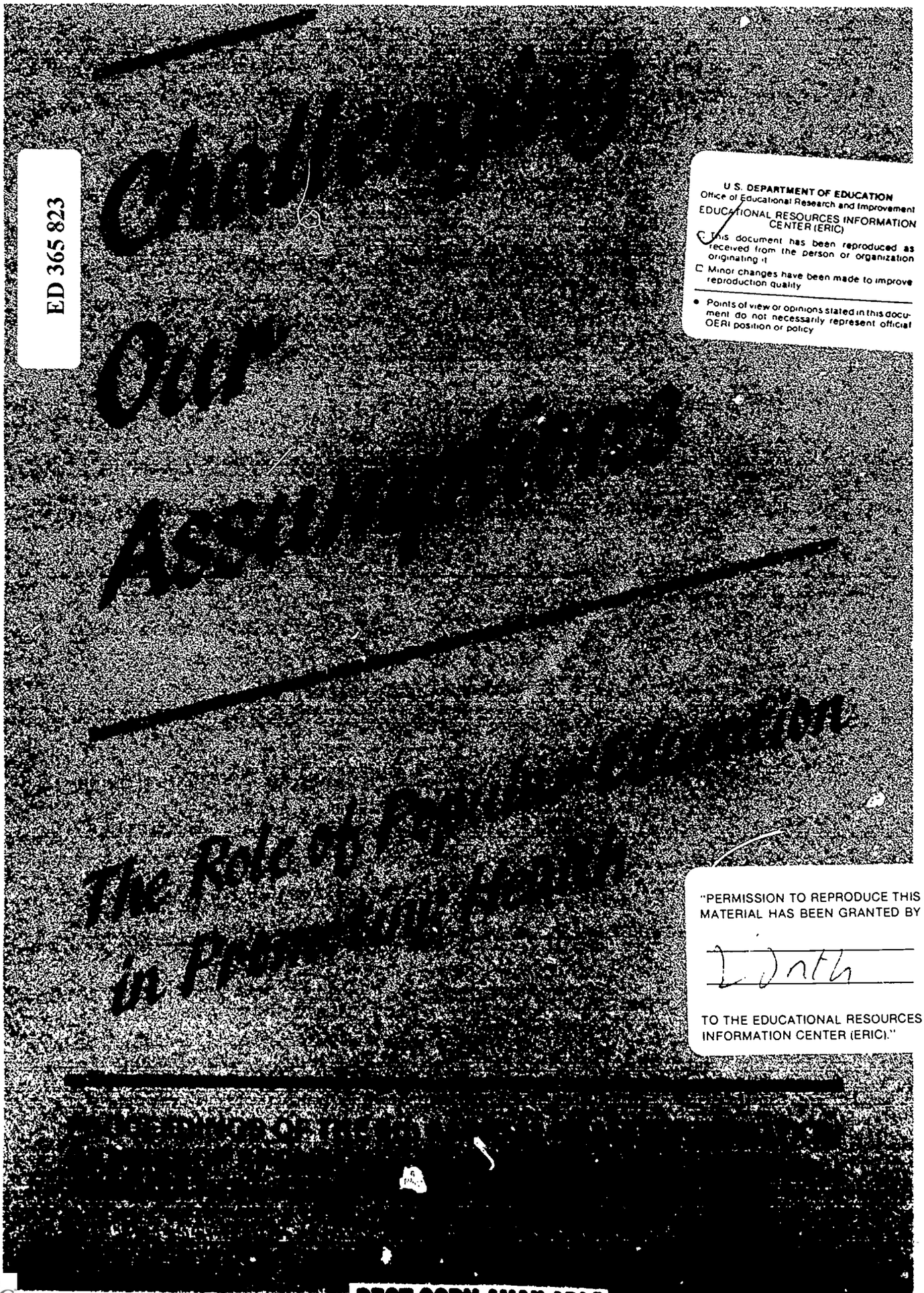
ED 365 823 CE 065 452

AUTHOR Farlow, D'arcy, Ed.
TITLE Challenging Our Assumptions: The Role of Popular Education in Promoting Health. Proceedings of the Annual Health Promotion Workshop (5th, Toronto, Ontario, Canada, September 25, 1986 and October 9, 1986).
INSTITUTION Ontario Ministry of Health, Toronto.; Ontario Public Health Association, Toronto.
PUB DATE Jan 87
NOTE 24p.
PUB TYPE Collected Works - Conference Proceedings (021)

EDRS PRICE MF01/PC01 Plus Postage.
DESCRIPTORS *Allied Health Occupations Education; Foreign Countries; *Group Activities; Guidelines; *Health Promotion; *Learning Activities; Models; Professional Continuing Education; *Role of Education; Teaching Methods; *Workshops
IDENTIFIERS Canada; *Popular Education

ABSTRACT

This document reports on a health promotion divisional workshop on popular education (PE) that was conducted to teach health promoters/educators to use PE methodology to analyze their educational work and role as health promoters and to learn to apply PE methodology during the health promotion activities. Information on the history and characteristics of PE is presented along with a model for a health promotion divisional workshop. The model, which was based on PE methodology, includes three steps: action (determining the tenets and role of health promotion), reflection (deepening analysis of the health promotion process), and action (developing plans for application of PE methodology). Each step is illustrated through case studies. This document contains information on the history of PE, the workshop planning model, and the case studies. Appended are a summary of comments/suggestions regarding the workshop, tips for planning workshops, a 35-item resource list, names/addresses of the workshop participants, and descriptions of participatory techniques for use in conducting workshops. Among the techniques outlined are exercises for helping participants get to know one another, energizing discussion groups, and identifying and analyzing common problems. (MN)



ACKNOWLEDGEMENTS

These proceedings not only describe the popular education process, they also represent one of the fundamental characteristics of popular education — a collective effort.

Initial thanks must go to the members of the OPHA Health Promotion Divisional workshop subcommittee for their enthusiasm, and energy in organizing two workshops and one follow-up session. It was a pleasure to work with Ruth Armstrong, John Keays, Marg Malone, Sheryl Mitchell, Katherine Slater, and Alison Stirling.

Of course, the workshops would not have been possible without the valuable contributions of Jane Adams, Rick Arnold, and Bev Burke. In the planning stages, they provided ongoing support and suggestions to the workshop subcommittee. Their excellent organization of the workshop format combined with the manner in which they facilitated the workshops, generated a warm, open atmosphere that elicited creativity and fun. In addition, Appendices B and C on popular education methodology were written for the proceedings by Rick, Bev and Jane.

We greatly appreciate the Ministry of Health's financial support in the production of these proceedings.

I would also like to acknowledge the work of the other people who assisted in the booklet's production. The workers of Dumont Press Graphix provided their consultation and expertise in the typesetting and production of the proceedings.

Finally, I would like to thank you, the participants, for your energy, your involvement, and your ideas. It's because of you that the proceedings were written.

D'Arcy Farlow
1986 Coordinator, OPHA Health Promotion Divisional Workshop
January 1987

TABLE OF CONTENTS

INTRODUCTION

Community participation in health care is not a new concept. In Canada, during the 1960's and 1970's, a series of reports discussed the issue of consumer participation in health care planning (Report of the Royal Commission on Health Services, 1965; Foulkes Report, 1973; Health Planning Task Force of Ontario, 1974; Manitoba White Paper, 1972; Hastings Report 1973; Castonguay - Nepveau Commission, 1967-72)

At the international level, the notion of communities involving themselves in primary health care was endorsed by the Declaration of Alma Ata (World Health Organization, 1978). Participation in the planning and implementation of health care was perceived as the right of all communities and individuals.

A more recent document prepared by the WHO Working Group on Health Promotion (1), examined the role of the individual and community in the promotion of health.

> "Health promotion is the process of enabling people to increase control over, and to improve their health."
> "Health promotion involves the population as a whole in the context of their everyday life..."
> "Health promotion aims particularly at effective and concrete public participation."

Honourable Jake Epp, Minister of National Health and Welfare, reiterated these views in an address to the Canadian Public Health Association's 77th Annual Conference (2). He outlined six health promotion strategies for generating health in the Canadian population and one of these strategies emphasized citizen participation in health promotion.

> "The purpose of this approach is to create the framework within which people can act as agents and advocates on their own behalf."

Adult education plays an important role in the encouragement of community participation in health. Popular education in particular, is an approach to adult education that provides the links, "between analysis and action, between personal experiences and social structures, between issues and between movements". (3)

The Health Promotion Divisional Workshops on Popular Education, which were held in Toronto on September 25, 1986, and October 9, 1986, were organized with two broad goals in mind:

- As health promoters/educators we would use the popular educational process to critically analyze our educational work and the roles that we assume as health promoters.
- As participants we would experience popular education methodology and subsequently be able to apply some of the concepts to our work.

Out of these original goals emerged six objectives:

- to explore an approach to health promotion that included social action
- to critically reflect on our work as health promoters/educators
- to introduce the basic elements of popular education
- to identify the possibilities and pitfalls facing health promoters as change agents
- to build a network of health promoters using popular education
- to initiate a plan for the application of popular education to our work.

As stated, the goals and objectives raise some obvious questions — What is popular education? What are the historical roots of this approach to adult education and how is it defined? How does one apply the popular education approach to their work?

We decided that the best way to answer all of these questions was to present the proceedings as a case study or a "how to manual". Rather than simply summarizing the events, our intent is to produce a working tool for both the participants and for anyone else who is interested in the application of popular education to the field of health promotion.

REFERENCES

1. World Health Organization. Working Group on Concepts and Principles of Health Promotion. *Health Promotion: A Discussion Document on the Concepts and Principles*. Copenhagen, July 1984.

2. Epp, J., Hon. "National Strategies for Health Promotion". An Address to the Canadian Public Health Association's 77th Annual Conference. *Can. J. of Pub. Health*. July/Aug. 1986, 77:243-247.

3. Arnold, R., D. Barndt, B. Burke. *A New Weave: Popular Education in Canada and Central America*. Toronto: CUSO Development Education and Ontario Institute for Studies in Education, 1985.

THE HISTORY OF POPULAR EDUCATION

Popular education traces its roots back to Brazil in the 1960's with the literacy training program of an educator named Paulo Freire. In contrast to the traditional educational system, which dated back to colonial times and tended to portray the existing norms and values of a small elite, Freire's students learned to read and write through discussion of basic problems that they were experiencing — such as the lack of access to agricultural land. As the causes of their problems became clear, the students discussed which joint actions could be taken to change their situation. The term used for this process of action/reflection/action, was *conscientization!*

During the 1970's, popular education was shaped by the growth of mass-based movements for social change in South America, leading to the expansion and enrichment of the methodology developed by Freire. During these years, popular education evolved as an educational approach especially designed to help the poor develop the skills needed to organize and take more control over their own lives.

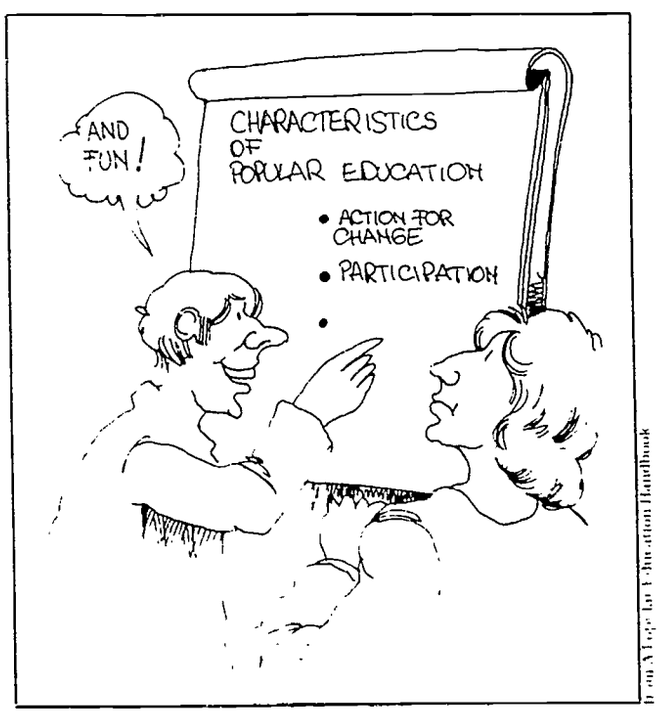
In the 1980's, popular education is again making new strides — this time in Central America, especially Nicaragua. In a massive literacy crusade modelled on the popular education approach, 100,000 Nicaraguan volunteers taught 400,000 people how to read and write, thus reducing the rate of illiteracy from 51% to 12% in just 6 months. The continuing adult education program, which consists of 24,000 former literacy students as the teachers, ensures that literacy skills will not be lost. As another example, the popular health campaign trained thousands of Nicaraguans to develop education and action programs designed to eliminate lethal diseases such as malaria.

Canada has its own history of popular education. One example is the National Farm Radio Forum which was broadcast by the CBC in the 1940's. At one point in 1949/50, the program reached 1,600 forums with almost 21,000 rural participants. The participants were encouraged to discuss the causes of some of their problems and to take action to remedy them. The radio forums died out, partially in response to corporate lobbying which claimed that "controversial" topics should not be presented in the forums.

Today, educators working in a range of community organizations in Canada, are drawing from our own rich history of educating for social change and combining this with adaptations of the popular education methodology, to meet their specific educational and organizing needs.

Written for the Proceedings by Rick Arnold

CHARACTERISTICS OF POPULAR EDUCATION



- Everyone teaches; everyone learns.
- Respect for the learner.
- The starting point is the concrete experience of the learner.
- Involves a high level of participation.
- Represents a collective effort.
- Consists of an ongoing process, not limited to a workshop.
- Leads to action for change.
- Stresses the creation of new knowledge.
- Causes us to reflect on what we've done to improve what we are going to do.
- Strengthens the ability of people to organize themselves.
- Links local experiences to historical and global processes.

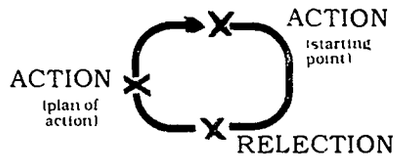
THE LEARNING LOOM
A WORKSHOP PLANNING MODEL
FOR HEALTH PROMOTION DIVISIONAL WORKSHOP

Theme: Popular Education
Guiding Thread: Critical reflection on role of health promoter as social change agent and popular education as a tool for that work.

Design Logic	WHY: Objectives	WHAT: Themes, Sub-themes	HOW: Activities, Procedures	WITH WHAT: Resources	WHO: Facilitators	WHEN: Time
1) Start with experiences and perceptions of participants	To introduce each other To build a group	Fears and fantasies Who we are who they are	1 At Registration — Fears and Fantasies to be noted on wall Name Tag — name plus a symbol that shows how you see yourself as an educator 2 Lifeboats (to include sharing name tags in one group)	Flip chart prepared and markers Name tags and markers	Jane Bev	8 30 - 9.00 9:00 - 9:30
	To introduce ourselves and the workshop agenda and objectives		Review fears and fantasies	Fears and Fantasies papers. Prepared agenda and objectives	Jane	9.30 - 9.40
	To introduce the basic elements of popular education	History Characteristics Methodology Use Validity	Lecturette -- review methodology and history of popular education	Prepared flip chart notes	Rick	9 40 10 00
	To identify common problems contradictions in participant education work		Sociodrama (paper bag theatre) in 6 prearranged groups. Task 1 Brainstorm problems/contradictions you face in your educational work as a health promoter 2 Choose the most important and develop a 3 minute skit to illustrate (choose characters, develop story line)	6 paper bags with props Prepared list of groups. 6 facilitators 6 work areas Task on sheet for each group	Jane to introduce Rick, Bev and 4 volunteer facilitators	10:00 - 10 45
			COFFEE			10 45 - 11 00
2) Deepen analysis develop new skills and tools			Plenary — see skits, synthesize problems Dotmocracy – prioritize 3 main problems contradictions and choose work group for p m	Flip chart etc Dots	Rick Jane	11 00 - 11:45 11 45 - 12.00
			LUNCH			12.00 1 00 pm
			Energizer -- possible post office		Rick	1:00 - 1.15 pm
	To analyze the causes (who benefits who loses) of problems identified		3 groups – Mini Ah-Hah! (participants to do drawing) Plenary some brief report back to include listing of main actors identified by all groups	Jane to develop questions Lots of paper up in each room Coloured markers Task sheet	all Jane	1:15 - 2 00 pm 2 00 2:30 pm
	To analyze the role of the health promoter whose interests served		Possible energizer Personne a Personne Sculpture 1 Power relationship of actors identified (in full group) 2 Put health promotor in picture (allowing for different options) 3 Debrief (possibly using power scale) Whose interests do we want to promote in our education work? Note go on to look at popular education as a tool to promote interests of disadvantaged	Pieces of paper and tape to mark each actor Power scale outline	Bev	2 30 3.15 pm
			BREAK			3 15 3 30 pm
3) Develop plans for action	To relate popular education to experience work of participants		Guided reflection on what we've done so far, why, techniques used 1 Two case studies (prepared by participants) of use of social change methodology (10 minutes) 2 In two's, discuss possibilities of applying popular education to your work and share (asking people to be brief 15 minutes)	Flip charts in order on walls Examples prepared in advance Flip chart etc	Rick Jane	3 30 3 45 pm 3 45 4 15 pm
	To identify need for network and outline next step		In plenary identify needs Which ones we can meet together through network Who What, When and How for first step	Flip chart etc		4 15 4 45 pm
4) Evaluation	To evaluate the workshop		Have people fill out form ask for structured comments (what they liked how it could be improved)	Evaluation form	Rick	4 45 5 00 pm

POPULAR EDUCATION METHODOLOGY

There are three action steps in popular education methodology — ACTION/REFLECTION/ACTION. It is an ongoing dialectical process where the action developed becomes the new starting point.



Below, is an example of this process as it was used for the health promotion workshops.

PROGRAM LOGIC	HEALTH PROMOTION WORKSHOP
Step one: ACTION	• sharing of our experience and perceptions of our role as health educators/promoters • identifying common problems
Step two: REFLECTION	• analysis of the underlying causes of the problems identified • examination of our role within the larger context
Step three: ACTION	• application of the concepts of popular education to our work as health educators/promoters • initiation of ongoing network or support group

The matrix on the opposite page demonstrates the complete program planning model that was developed for the Toronto workshops. In the next section we will examine this model in more detail, as we follow the program logic and elaborate upon the outcomes of the exercises. For specific details on individual techniques please refer to Appendices B and C.

Before moving on to describe the exercises, it is worth noting that the methodology and techniques are not the only factors to consider when planning a workshop. Much of the success or failure of the popular education approach is dependent upon building a base of trust and support within a group so that participants will feel open to participating, questioning, problem solving, learning and enjoying themselves. Obviously the skill and experience of the facilitator(s) has a large impact upon the process.

Another important consideration is the size of the group. Both of the health promotion workshops had 35 to 40 participants with three facilitators. In their work as popular educators, Rick, Bev and Jane have found that regardless of the number of facilitators, the level of participation is diminished with groups of over 30 people. When planning these workshops we decided that although we risked losing some valuable, small group interaction, our priority was to introduce as many people as possible to popular education. Under different circumstances — when popular education is to be used specifically as a process for group problem solving — fewer participants would probably add to more intense participation and involvement.

STEP ONE: ACTION
(WHERE ARE WE COMING FROM?)

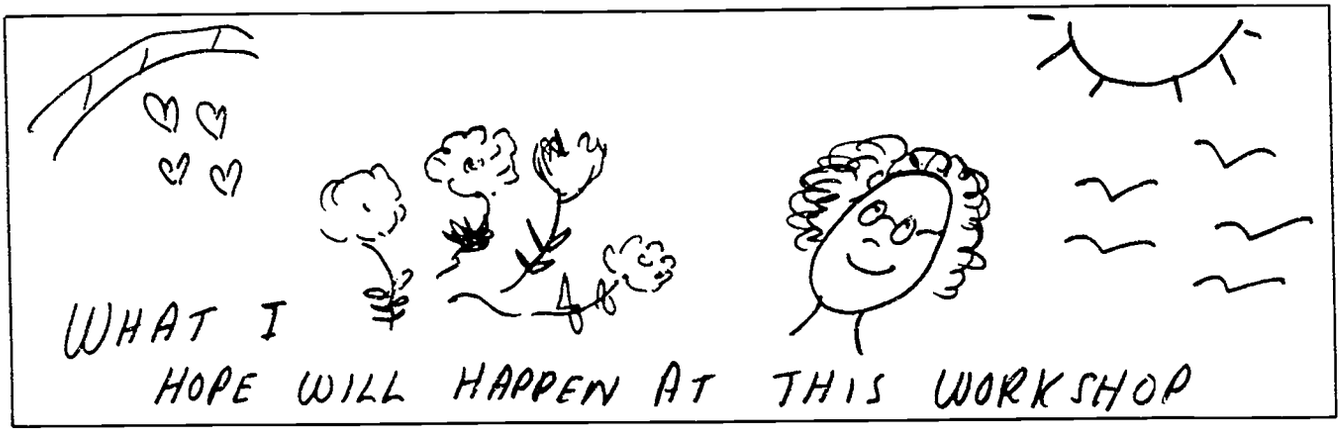
INTRODUCTORY EXERCISES

NAME TAGS AND LIFEBOATS

These early exercises involved participants in activity the moment they walked into the workshop. Name tags portrayed more than just a name — people were encouraged to draw their perceptions of their work as health educators on their labels.

With the Lifeboats exercise people were clustered into small groups with similar characteristics (e.g. same birthplace). The technique served as an energizer while introducing participants to each other and (hopefully) diminishing natural inhibitions or barriers.

"Warm-ups were excellent."
"Enjoyed the networking — meeting others with similar interests."
"Networking was great — made a few contacts."
"More time needed to exchange names, details of experience."
"A bit more direction re: people identifying where they work, with whom they work, how they work, on what they are working...."
"I would have appreciated a moment (or an exercise) at the very beginning to center on being here."
"Needed more biographical information on participants to allow me to really talk with the workers with whom I have common interests."



FEARS AND FANTASIES

Prior to the beginning of the workshop, participants wrote down their fears and expectations for the day's events. The comments were posted on the wall and reviewed by the facilitator during the initial workshop plenary. This exercise served the purpose of alerting the facilitator to people's concerns. At the same time participants, having had their hopes and fears addressed, could now turn their attention to learning and participating.

"I will be energized with some bright, innovative and creative ideas."
"That I will learn skills to take back and share with colleagues."
"That my creative energy will get a little nurturing."
"That I learn more about process in popular education."
"That much excitement will be generated and carry on past the workshop with network of health promoters."
"Exciting new ideas for delivering health education to socially disadvantaged groups."
"Opportunities to share with other health educators."

"That we will not participate in a lively way and it will fizzle . . . with some leaving in frustration."
"That I won't be energized."
"That my daily nitty gritty status quo preoccupations won't let go of my energy enough to be here."
"That the health care and educational systems do not change i.e. this workshop I hope will lead to change."
"That folks will leave thinking that popular education won't work in Ontario, Canada, Metro . . . ."
"Bored or boring participants (I hope I won't be boring)."

There was a suggestion that the fears and hopes could be reviewed again at the end of the day to determine if people's greatest or worst expectations had been met.

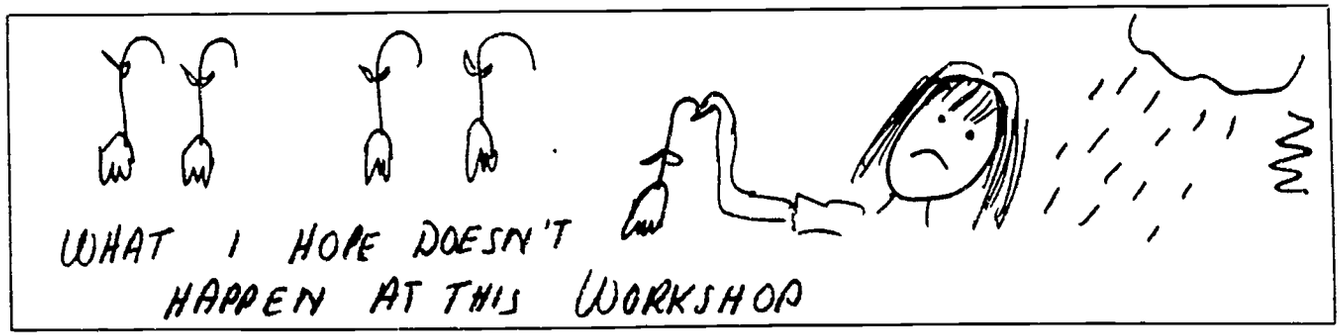
SOCIODRAMA — PAPER BAG THEATRE

The workshop participants were divided into groups of six and given a bag of props. Although the props (eggbeaters, shower caps etc.) bore little resemblance to the issues at hand, they proved to be a source of great ingenuity and humour.

Each group worked with a facilitator and brainstormed on the topic of "the problems/ contradictions that we face in our educational work as health promoters". The issues were presented as skits.

It was interesting to note that the members of the audience often added interpretations to the skits that the actors themselves hadn't considered. This contributed to the ongoing learning process of all group members.

Theoretically the different groups should have consisted of members who shared the same occupations or who worked in similar settings. In reality this proved to be a difficult task and in the end the lack of homogeneity in the groups reflected the heterogeneous nature of health promotion. As a matter of fact, one of the top ranking problems



identified by both workshops was the lack of a clear definition for the role of the health promoter.

Other problems identified by both workshops were:

Barriers or resistance of public to health promotion.

- media/pharmaceutical companies give consumers conflicting messages
- we're socialized into the sick care system — makes people resistant to new approach
- class and cultural differences exist between the health educator and clients

Structural (professional, institutional, territorial) barriers to creative change through health promotion.

- real needs seen as too political
- bureaucrats out of touch with community needs
- program guidelines don't match needs
- system meets professionals' not patients' needs

Funding.

- $ to curative services, only lip service paid to prevention
- no action on health promotion discrepancies in policies

Health professionals as barriers.

- egos/vested interests
- specialization contributes to fragmented approach to health
- lack of support for health promoter — isolation etc.

Lack of community to provide continuity and support for the work of the health promoter.

- powerlessness
- marginalization

STEP TWO: REFLECTION
(DEEPEN ANALYSIS)

DOTMOCRACY

After the problems demonstrated in the skits were synthesized into the lists presented above, participants were then given three dots and asked to chose their three priority problems. Coincidently, the three top ranking problems were the same in both Toronto workshops. They are presented below:

- Institutional/structural barriers to creative change *vis a vis* health promotion.
- Public resistance to health promotion
- The lack of a clear definition of the role of the health promoter

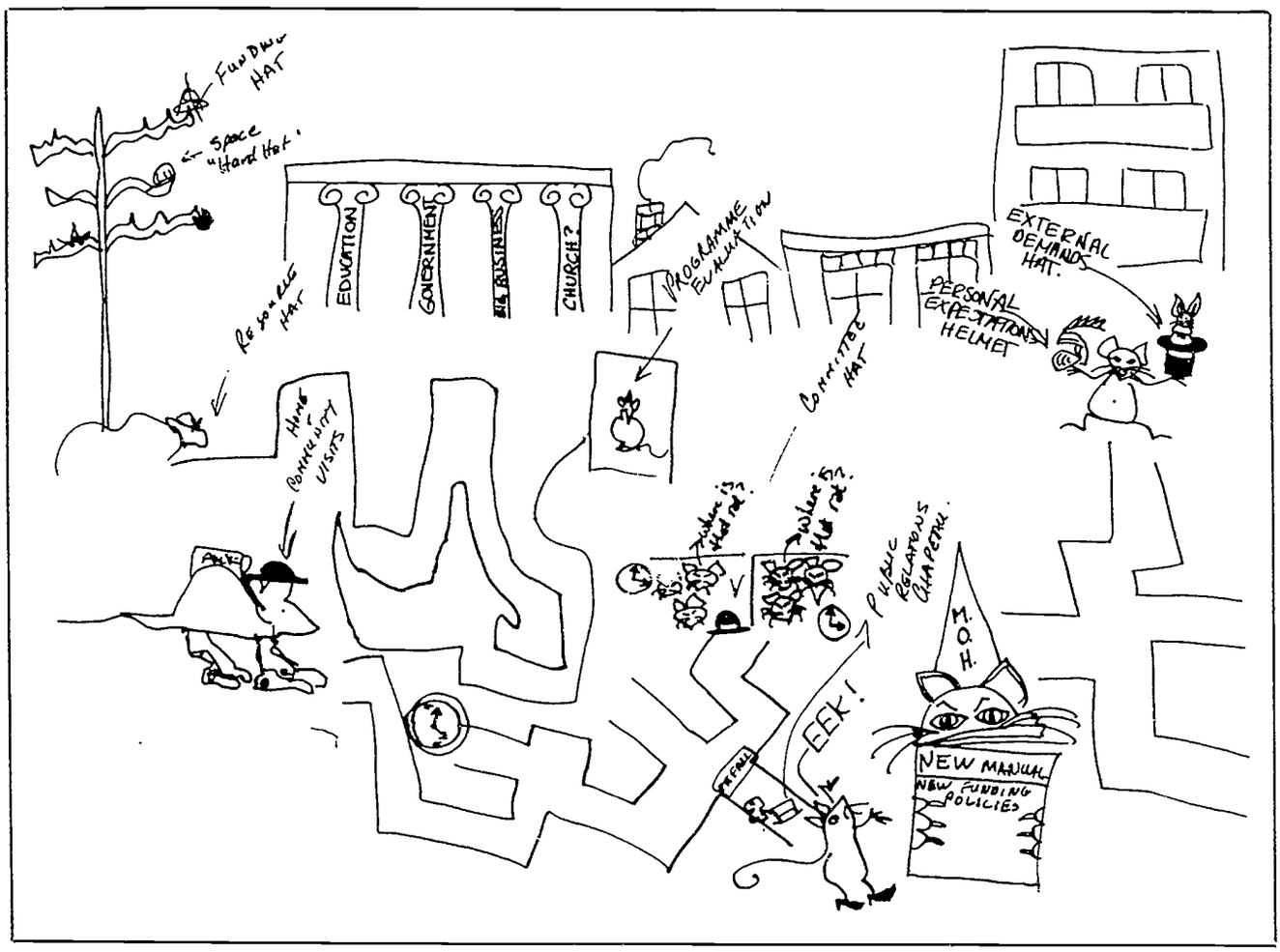
COLLECTIVE DRAWING OR MINI "AH HA"

Workshop participants divided into three groups and each group analyzed one of the priority problems in greater depth. Continuing to work in the creative mode, group members drew their perception of the stated problem and the context within which the problem exists..

As the drawings evolved so did the analysis. Through the use of symbols it was possible to draw out new interpretations or redefinitons of the problem.

One group tackled the issue of the role of the health promoter. (See diagram on page 8.)

The rat, of course, represents the health promoter fighting through a maze of demands and expectations. Constantly juggling hats, the health promoter races against the clock, runs into two concurrent committees while wearing the wrong hat, and encounters pitfalls when dealing with public relations and funding policies. With a knight's helmet ('personal expectations hat') in one hand and a magicians's hat ('external expectations hat') in the other hand, the rat struggles towards the goal of social change (cheese). The goal is never



reached. This is partially due to the obstacles created by big business, government, education and other institutions, and partially due to our inability to establish a clear definition of the health promoter.

It was suggested that some of the health promoter's problems could be resolved if a few of the hats were passed to other rats, if definite priorities could be set, and if time could be spent working with those involved in social change.

The second group examined the problem of public resistance to health promotion. People's perceptions were determined to be the main barriers to change. Our perceptions are derived from our cultural attitudes and values, plus our life experiences. External influences such as our educational system, the media, and the church, can all contribute to a blinkered approach to life. The group graphically compared this situation to a huge constipated bowel in desperate need of an enema. The question is, how do you unclog the system that contributes to an individual's barriers without causing undue distress to the person in the process? This group suggested that if the individual is not isolated, but instead is 'cushioned' or supported within a collective effort then barriers can be eliminated with less trauma.

The third group drew a brick wall to depict institutional barriers to change. The community was below the wall, the administrators were sitting on top of the wall, and the health educators were encompassed within the wall. Politicians, corporations, and certain sectors of research, work to ensure the ongoing functioning of the wall and the vested interests that it represents. Isolated within this wall, the health promoter struggles to connect to the community. The image is one of a single individual trying to create change in a vacuum. The drawing indicated that the health promoter needs to work more closely with groups who are already organized as well as with those who are not organized.

The groups briefly reported on their drawings in the plenary session and during the ensuing discussion, the facilitator asked questions that encouraged participants to reflect on the issues underlying the problems that had been presented. For example:

What are the obstacles in addressing this problem?
Who is benefitting/who is losing?
What are the resources or possibilities that we bring to the problem?
Where are the areas where action is possible?
Who are the key actors?

In response to the last question, the following actors were identified:
Government - municipal/provincial/federal
Hospital
Doctor
Patient
Nurse - hospital/public health
Medical Officer of Health
Board of Health
Big Business
Organized Community
Unorganized Community
Media
Church
Patriarchal System
Health promoter enhancing his/her professional status
Burnt out health promoter
Health promoter — advocate of social change
Taxpayers

In order to determine the actors' relationships to each other — with respect to their control over decision making and their access to health care system resources — the *sculpturing* technique was used.

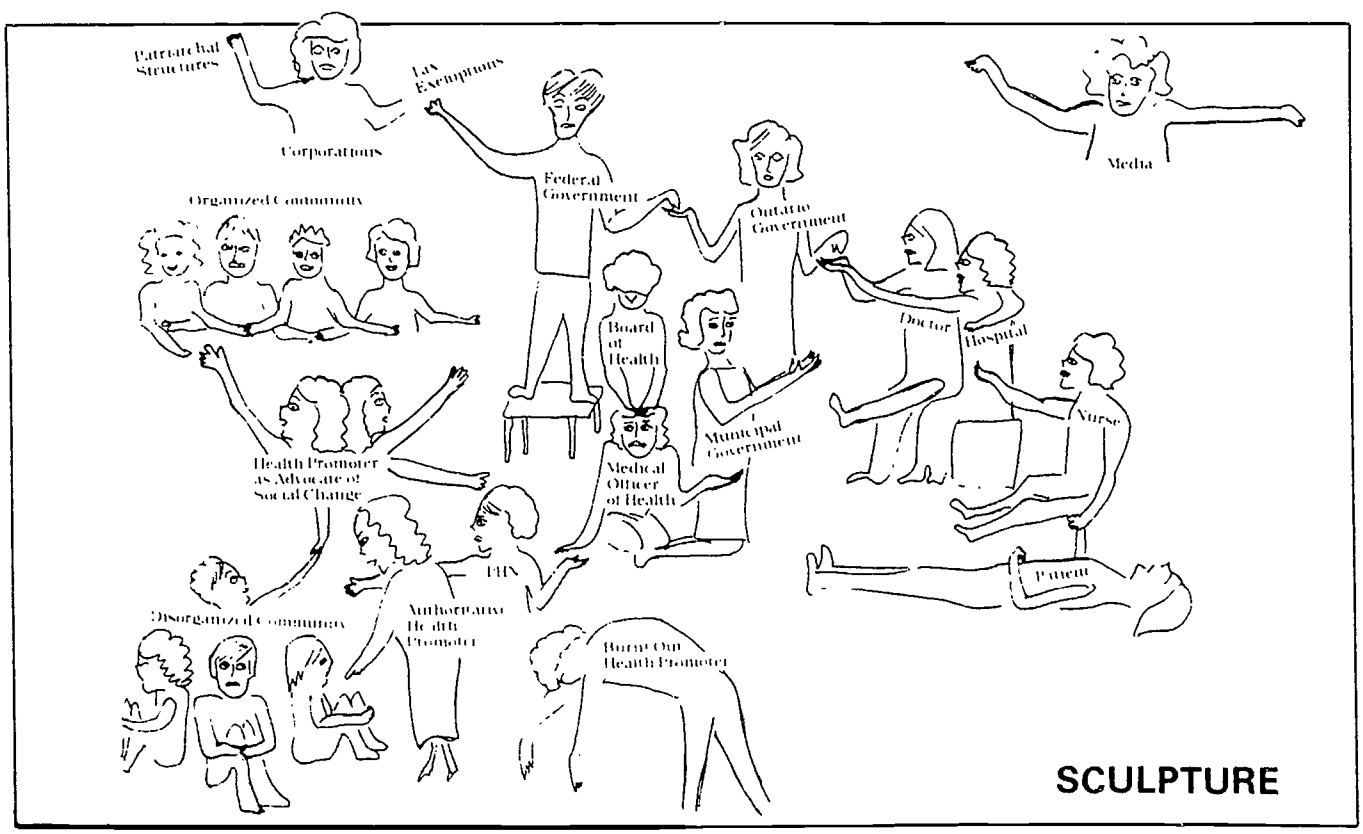
SCULPTURING

Sculpturing is an exercise that uses people (rather than clay) to create a visual image of a particular theme. In our case we were analyzing the role of the health educator within the health care system and the community. Volunteers from the group represented the different actors mentioned above, and positioned themselves in such a way that the power relationships were conveyed. The placement of the various actors within the growing picture was not a straight forward task and the exercise provoked some good discussions. However everyone's perspective was listened to, and ultimately the sculpture was built by consensus.

Determining where to place the health promoter was, naturally, the most difficult decision. There was the "authoritative" health promoter preaching down to an acquiescent community, the "burnt out" health promoter who was exhausted and unable to connect, and finally the health promoter as "social advocate" whose hands attempted to link with the disorganized community, the organized community, other professionals, policy makers, ...

In the debriefing afterwards, we acknowledged once again that the role of the health educator can be very demanding and sometimes unrealistic. Furthermore, it is not always clear as to who benefits from health promotion. Perhaps our focus should be more specific — but where do we concentrate our attention? And can we afford to limit the scope of our activities at a time when health promotion should be developing as broad a profile as possible?

Obviously the sculpturing exercise raised some interesting issues which could only be touched upon within the workshop. However, we did discuss how popular education could assist us in resolving some of our concerns regarding our work as health promoters/social advocates.



SCULPTURE

STEP THREE: ACTION
(DEVELOP PLANS FOR APPLICATION)

GUIDED REFLECTION

At this point in the workshop we took a moment to review the process. Throughout the day we had been in the role of participants — using the popular education approach to identify common problems (Sociodrama, Dotmocracy), to analyze the problems in greater depth (Collective Drawing) and to determine the power structures within the health care system (Sculpturing). It is important to note that the techniques were chosen to meet the objectives, not the other way around.

Now it was time to resume our role as health promoters and discuss if and how popular education could be applied to our work.

TWO CASE STUDIES

The case studies were presented by two health educators who had developed programs based on the popular education process. Although the context and focus of each program was quite different, there were many similarities in the underlying philosophy and goals of the programs. In both cases, traditionally powerless groups began to take a more active role in understanding and controlling the circumstances surrounding their socio-health problems. Acting upon the concepts of popular education, the health promoter facilitated a process of support and analysis that led to active outcomes and the empowerment of the individuals concerned.

CASE STUDY 1

I work as a community health educator in Parkdale Community Health Centre. The residents of this low-income, immigrant-rich community in Toronto originally envisioned a centre offering an integration of social, medical, information, and advocacy services. Although funding has been limited to medical and health education services, the Centre has maintained a strong socio-health vision in the goal statements. PCHC aims to address the area's broad range of concerns through a process of community development. This entails involving those most affected, in changing the environmental and structural conditions that contribute to their problems. One of these problems is family violence.

In 1984, when I began developing community health education programs, the issue of battered women arose as a significant concern for the health centre, the community legal services, the information centre and other groups. We met and decided to take a two pronged approach to the issue: (1) interagency coordination and education and (2) a support group for women. Our objectives would be achieved through the use of popular education methodology.

All community workers dealing with family violence gathered to:
- review current services
- educate ourselves through analysis of the causes of wife assault and clarification of our own values
- act upon the problem by broadening services (medical, legal, financial and housing) and by advocating appropriate changes to existing legislation and the establishment of police outreach

Co-facilitators from legal services and the health centre began a weekly support group for battered women. The co-facilitators were not battered women and our role was to listen and learn rather than teach. Each session of the support group consisted of the following:
- anecdotes/sharing of common experiences and pain
- analysis and reflection on the causes — using drawing and sociodrama to examine the power structures that contribute to women's vulnerability and economic dependency
- closing of group session with action plans, including support and safety. Outcomes are discussed the next week

The support group for battered women has proven to be an essential form of assistance for some of the women. However, there is a problem with a lack of continuity of the participants and this can be disruptive to the group. Furthermore, we are faced with the ongoing battle of trying to secure funding. Finally, co-facilitating this support group requires a tremendous amount of energy. What is needed is a counsellor or outreach worker to focus on this problem and related issues.

Alison Stirling — Health Educator, Parkdale Community Health Centre

CASE STUDY 2

I was working with a storefront health promotion agency staffed by Public Health nurses, and was provided with an opportunity to research, develop and implement a neighbourhood health support project. The project was called SHARE: Social Health Awareness and Resources Exchange.

The goal of the project was to facilitate the organizing and implementation of a neighbourhood health support program which would provide residents with an opportunity to work together for a healthier community. The project had six phases:
1. Research and development of the project
2. Hiring and orientation of three outreach workers, two of whom spoke fluent Italian
3. Initial outreach to community residents to identify general concerns and needs

4 Collaborative analysis of data (eg. collaboration between the SHARE community workers and the community itself) and selection of the most immediate issues
5 Community organizing for action
6 Evaluation of the overall project

The methodology was based on participatory research methods derived from the popular education approach, and consisted of:

- Workers knocking on every door in a target area, talking to residents to determine community health concerns
- Holding meetings to collectively discuss these common concerns
- Forming groups to work on the specific issues
- Initiating some of the more concrete concerns such as "neighbourhood watch"
- Starting other groups (eg. ratepayers group, exercise group, English classes for immigrant women)

The evaluation results indicated that residents felt that their community had improved. Furthermore, there was a better understanding of the needs of the different ethnic groups.

However, the project had certain limitations such as the fact that it was only a six month pilot study. Although this period of time was long enough to generate interest, participation, debate, and community spirit, there was a definite need for a leader in order to maintain the momentum. Also, more time was needed to examine some of the underlying problems in greater depth. For example, why were the streets so dangerous that a neighbourhood watch was required?

A project like this is extremely energizing yet at the same time it requires a great deal of planning, flexibility, stamina, and commitment. If the sponsoring agency uses temporary staff to initiate the project then the agency must be prepared to commit time and energy to its continuation.

Vying political interests can interfere with the process if this potential is not foreseen. In addition, once a community is mobilized to critically analyze how socio-economic factors affect their health, then the political, social, and economic ramifications of this may be felt in areas where they are not appreciated. Therefore one needs to be prepared for potential social changes once a community feels empowered.

Finally, one needs to be sensitive to the different cultural norms and sets of values that people bring to a project of this nature.

Marg Malone, Doctoral work in Sociology

SMALL GROUP DISCUSSION AND SHARING

Following the case study presentations, we broke into two's and discussed how popular education might play a role in the work we were doing with different focus groups. The ideas that were generated were shared in a brief plenary session. They are recounted below:

- Adapt the popular education approach to staff development needs (e.g. assist nurses in looking at common problems in their jobs, the cause of those problems, and how to solve them).
- Encourage children in elementary grades to act out their perceptions of nutritional needs.
- Work with teens to create sociodramas on the topics of drugs, alcohol, and smoking.
- Use popular education with the Mayor's Committee on Aging to think through the needs of seniors in different ethnic groups (e.g. the committee would envision the ideal for an aging person, hear the reality through presentations from ethnic groups, reflect, and act).
- Apply popular education methodology to a program geared towards enhancing the mental health of women. Hopefully the process would assist the women in identifying their needs, problem solving, and ultimately taking on responsibility for the continuation of the group.
- Organize an event at the Community Health Centre that would be participative. (e.g. plan a walk through the community that would highlight specific health concerns such as pollution. At the end of the walk, participants could draw their vision of a healthy community.) Following this would be a session focusing on strategies for change.
- Energize a group of low income mothers developing a brief for the Social Assistance Review, by involving them in collective drawings. The drawings could be presented to the task force.
- Use the popular education approach to resolve board/staff tensions (e.g. get them working together to determine the important issues in the community).
- Ascertain the fears and worries of a prenatal class for Spanish speaking people through the use of collective drawing.

NEXT STEPS

In the final plenary session, there was a full group discussion of the strategies that we should employ to ensure that there would be some form of follow-up after the workshop. If we think back to the beginning of the day, one of the original objectives of the workshop was to initiate a network of health promoters using popular education. The desire for ongoing contact was also expressed as a fantasy by one of the participants:

> "That much excitement will be generated and carry on past the workshop with network of health promoters."

During this discussion at the end of the day, building a network was mentioned again as a follow-up strategy. Suggestions focused on why and how we should develop such a group.

WHY?
- A group to share resources and ideas
- Know that people are facing the same problems
- Access to what others are doing
- Learn different educational approaches
- Identify areas of common interest

HOW?
- Use the network we have available regionally and inside Toronto
- Build links with individuals trying to change things from within — reduce isolation
- Obtain a list of participants' names, phone numbers, places of work, interests etc.
- Develop a newsletter
- Hold evening sessions
- Include an action component — political action? — as individuals or as a group
- Maintain ongoing communication with groups other than health promoters
- Voice interests in particular areas (e.g. women's programs, government funding)
- Establish a subcommittee within an existing organization, to maintain contact and share information
- Hold a half day workshop for brainstorming and discussion of further application of popular education

NOTE:
A half day follow-up session was organized for workshop participants by the OPHA Health Promotion Division, and was held on January 30th, 1987. We were pleased with the enthusiastic and energetic turnout.

APPENDIX A
THE EVALUATION: A SUMMARY OF COMMENTS AND SUGGESTIONS

What did you like best about the workshop?
- The participatory/experiential approach.
- The variety of techniques (all were mentioned in particular).
- The atmosphere — open, relaxed etc.
- The organization of the workshop — including advance mailing and materials in kit.
- The facilitators.
- The fun/creativity.
- The exchange time for practical ideas.

What could have been improved?
- More time needed for application.
- Time overall — could have been two days/it was a long afternoon.
- More time for networking especially at the beginning of the day.
- Collective drawing was a little too abstract — better if focused more at micro level.
- Sculpture exercise too slow.
- Could have started at a higher level and moved faster, given the well informed group.
- Cost — for those who had to pay their own way.

What could you use from the workshop? How?
- Generally useful — techniques/method/contacts — however needs follow-up.

Any other comments?
- I'm exhausted! You put a lot of positive into my day.
- Well done, nice combination of facilitation styles. It worked!
- Facilitators were wonderful.
- Was well worth the registration fee.
- I feel that the problems and barriers identified are common to our group but we are not in a position of power to bring about change. This seminar should be emphasized and presented to the people at the top (e.g. administrators, MOHs, politicians etc).
- Again and again and again! We are the committed talking to the converted. The people who seem to need to be reached by a new approach are apparently unreachable.
- Needs follow-up to keep up the enthusiasm and support. How to increase this group's capacity, experience, and cohesiveness?
- Interested in next step of networking.
- Did not think we were trying to build an organization!
- Need for more small group experience at the beginning, for people to get to know each other and work together more effectively.
- The networking is terrific and one of the most useful aspects of the day. I'm tired! Thanks!

APPENDIX B
TIPS FOR PLANNING A WORKSHOP

A CHECKLIST FOR CHOOSING TECHNIQUES

- Do not choose the activity first. Rather set the objective and then decide how best to meet it.
- Be familiar with the possibilities and limitations of each technique or resource you will use, and try to be familiar with a number of different ones.
- Be ready to adapt techniques to suit your group. For example, the way you use drama, with a high school class, a trade union or church group varies greatly, given the different "cultures" they represent. "Discussion" can begin in twos, for groups where only a few people usually speak etc.
- How many people and how much time you have will limit which techniques or resources you can use.
- You should feel comfortable leading the activity — although without some controlled risk taking, you will never expand your "tool kit". Work with someone whenever you can, and especially when you are trying something new.
- Use techniques that others can also use — demystify them as you use them. Sometimes, the simplest thing you can think of is the best!
- Be creative! Sometimes it is necessary to "remake" a technique into something new and useful for your particular situation.

SOME GENERAL TOOLS USED IN THE WORKSHOPS

USING A FLIP CHART

Putting peoples' ideas up on paper helps underline that their contribution has value. The flip chart also helps collectivize the learning process so that everyone can see, and therefore agree/disagree with points or conclusions listed. As was pointed out in the first workshop, it is also important that everyone can see the material — so write clearly with a dark pen!

WORKING IN SMALL GROUPS

Small group work increases participation. It also offers the opportunity for working at several tasks simultaneously. (Everyone does not have to discuss everything.) When using small groups be sure that your instructions are clear. It helps to write them out on sheets of paper for each group, or up on the flip chart. Tell groups how much time they have. Also think ahead as to where the groups will meet and how they will be chosen. (Numbering off, prearranged groups etc.)

TO PRIORITIZE AND ALLOW PEOPLE TO CHOOSE THE THEME THEY WISH TO DISCUSS

Dotmocracy

Have the choices clearly listed on the flip chart and give everyone two coloured dots. Ask participants to stick the dots beside the two ideas of their choice. The number of dots beside an idea indicates priority.

Wall Groupings

Once you have the priority areas, post them on the wall at various points and ask people to "vote with their feet" — to congregate around the decision of their choice. You can then negotiate, asking people to take their second choice if the groups are uneven.

APPENDIX C
PARTICIPATORY TECHNIQUES

What follows is a brief "how to" for each technique used in the workshops. Further references are given for some of the techniques described, to suggest alternative uses.

GETTING TO KNOW EACH OTHER

MAKE-YOUR-OWN NAME TAGS

Materials:
Large name tags and lots of coloured markers.

Procedure:
Ask people to design their own name tags, and to include information relevant to the workshop theme which can be shared during the introductions. We asked participants to depict how they view themselves as educators. This information was shared in small groups during "lifeboats" described below.

FEARS AND FANTASIES

Purpose:
This exercise is designed to help people state, early on, their expectations for the workshop, meeting, training session, etc.
Everyone comes into a new situation with hopes (and it is useful to confirm which of these will be accomplished during the event), and fears (and it is essential to get these stated early on so that people can put them aside and go on with learning and participating).

Materials:
Several magic markers of different colours. 4-6 pieces of flip chart paper attached to a wall. On the top of the pages are two statements: WHAT I HOPE DOES NOT HAPPEN AT THIS WORKSHOP and, on the other sheet WHAT I HOPE WILL HAPPEN AT THIS WORKSHOP.

Procedure:
As people come in, ask them to write, on each of the two sheets, statements about their fears and their fantasies.
When the meeting has been called to order and introductions made, the facilitator is to read aloud the fears and fantasies from the sheets of paper. It is important to seriously acknowledge each contribution. Tell people which fantasies will not be realized in this particular workshop and which fears may be, in fact, realized (e.g. playing games).
This is the facilitator's opportunity to check in with people and make sure she has designed the appropriate agenda. If there are concerns which she has not been aware of, she should not hesitate to seek direction from the group in changing the agenda even if this is distressing to do. Better a period of renegotiation than an irrelevant workshop!

Note: Additional Resources — *A New Weave*, pp. 81-82, and *Neighbourhood Action: Recipes for Change*, p. 50. (See Reference List at end of Appendix)

LIFEBOATS

Materials:
A large space free of coffee cups, chairs etc.

Procedure:
Share with the group the object of the exercise. Then explain that we are on a ship which has started to sink and we will have to evacuate into lifeboats. However, everyone will have to listen carefully to make sure that they are in the right lifeboat and once there, stay close together so as to avoid falling.
The facilitator can then call out distinguishing features for the lifeboats based on particularities of the group that it might be interesting to highlight. For example, we called the following lifeboats:

- where you work (Toronto, Metro, outside) (share names at this point)
- where you were born
- men/women
- children/no children
- by numbers — stopping once to share your name and where you work, and once to share what you put on your name tag

Note: Adapted from *A New Weave*, pp. 79-80. (See Reference List at end of Appendix)

ENERGIZERS

POST OFFICE

Materials:
A chair for everyone except the animator. An old envelope or piece of paper.

Procedure:
Ask everyone to sit in a chair. Be sure there are no empty chairs. Explain that you, as the postperson, will say for example: "I have a letter for everyone wearing glasses". At that moment, all those wearing glasses will change chairs. You will also try to find a chair and the person left over will become the next postperson. Also encourage letters which will require everyone to change chairs (e.g. "everyone with hair on his/her head").

PERSONNE A PERSONNE

Materials:
A large open space.
Procedure:

1. Choose a partner and stand in a large circle.
2. One person stands in the middle and is the caller (the animator could start).
3. The caller shouts out two parts of the body (e.g. "hands to head").
4. One person puts her hand on the head of her partner.
5. Two other parts of the body are called out (e.g. "knee to hip").
6. One person now touches her knee to the hip of her partner while still holding the first position.
7. The caller keeps shouting out combinations.
8. When the caller runs out of parts of the body to call, or sees that the contortions have reached a limit she calls " PERSONNE A PERSONNE".
9. This means CHANGE PARTNERS! Everyone changes their place in the circle and grabs a new partner.
10. The person left without a partner is the new caller and the game proceeds as before.

Note: Adapted from *Neighbourhood Action: Recipes for Change*. p. 15. (See Reference List at end of Appendix)

IDENTIFYING COMMON PROBLEMS

PAPER BAG THEATRE

Materials:
A paper bag of funny props for each group plus a meeting area, flip chart, markers, pens and tape for each group.
Procedure:
The groups are pre-divided and each person is asked to join with their assigned facilitator and group members. The facilitator keeps track of the time, makes sure the discussion stays on topic, and ensures that each person's ideas are heard. The group spends 30 minutes developing a skit on the topic. (In our workshop the topic was, "Problems or contradictions that you face in your educational work as health promoters".) No one should feel compelled to act if they are uncomfortable with role playing.
All the props should be used but not for their real purpose: they are adapted for use in the skit (e.g. an eggbeater could be used as a telephone).
Here is a suggested plan for your thirty minutes:
10 minutes — brainstorm problems/contradictions
5 minutes — select 1 or 2 problems to dramatize
10 minutes — plan the storyline for your skit and the roles people will take
5 minutes — adapt the props

Note: In our workshop the process actually took 45 minutes. This included the presentation of skits (in 2 groups — 3 or 4 skits in each) and the identification of the main problems in each skit.

SCULPTURING

There are many variations on sculpturing. The one presented here is an alternative to the technique used in the Toronto workshops. A description of the sculpturing method used in Toronto is described under the next section "Analyzing the Problem".

Materials:
A large open area.
Procedure:
In groups of 10-15, each participant is asked to identify a concrete situation that frustrates them in their work. The task is to build a picture of the situation, using other group members as the raw material. Participants are given a few minutes to think of a situation and decide how to portray it. Ask for a volunteer to begin and keep the process moving until everyone has had a chance. The group is then asked to choose the most representative example to show back to other groups — making any alterations required. The group also decides how to explain a) the frustrations depicted b) the actors involved, and c) suggested causes of the frustration.
Debriefing:
In the plenary, each group shows and explains the sculpture. The facilitator notes points on flip chart. In twos, participants are asked to discuss who benefits and who loses in the scenes; and to reflect on the role of the health promoter. Share in plenary and summarize.

ANALYZING THE PROBLEMS

COLLECTIVE DRAWING

This is a creative and collective way in which a group can begin to analyze the social, political and economic context within which they live or work. It is a process that can be used as a cooperative problem solving tool.

It takes about 2 hours to properly work through the drawing and the discussion, but it can, if time permits, provide food for much longer discussion.

It probably works best with a group of from 6-15 in number, and if the group is much larger, two drawings can be created.

Materials:

A large sheet of paper, approximately 3' x 5'. Lots of magic markers of a variety of colours. Chairs arranged in a semi-circle so that all group members can walk easily to and from the drawing.

Method:

Attach the large sheet of paper to a wall. Put the pens nearby within easy reach. The facilitator leads the process, especially at first with questions, validations and affirmations, and occasionally suggestions. The group members do the drawing.

Procedure:

1. The facilitator should wait for group members to suggest symbols and images to represent the factors in the problem or analysis. If she starts drawing, others will be reluctant.

2. Have fun with this process . . . it is not necessary to worry about doing it "right". Be patient! It takes time for people to get their imaginations in gear and think visually. In fact, it would be a good idea to do a few warm-up exercises in advance, exercises which stimulate the right side of the brain.

3. Because it is awkward for people to step forward and be creative, carefully validate and confirm everyone's contribution, especially at the beginning.

4. Allow yourself to really work with the symbols people suggest. Don't be too quick to hurry on with another element of analysis. Look for the second and third interpretations of what that symbol could mean. If someone comes up with an octopus, for example, ask the group to reflect on what each of the arms is doing, what does the quality of its skin imply, does it have an expression on its face, is there any significance to its being under water, who is it reaching out to, who is it repelling, etc.

5. The facilitator's job is to ask provocative questions and if the process gets stuck, to lead the group in a process of enquiry to find out where the block is, and how to unblock. It could be that a contradiction, difference of opinion or conflict is being uncovered.

6. If there is such a difference, continue working with it, staying in the "symbolic" imagery as much as possible. If concensus cannot be reached, indicate clearly on the drawing where the difference occurs so that it will be taken into account later, and dealt with. Corrections can be made to the drawing if people change their minds.

7. The facilitator should question, summarize and point out interesting correlations and connections as the drawing develops. She is to slow down the process so that symbols are explored for meaning, and discussion can build on the appropriateness of the symbols.

8. Be very sure to start with a clear statement of the problem or analysis. For example: INSTITUTIONAL BARRIERS TO HEALTH EDUCATION: WHY DOES THIS PROBLEM EXIST?

9. Here are a few questions the facilitator can use to help the process along. The questions you will really use depend on what might be needed at the time:
   a) How would you symbolize this problem? (affirm suggestions) Who would like to get up and put this on the mural? Where do you think the symbol should be placed? Top? Bottom?
   b) If this is a character, what is he/she/it doing?
   c) What is the expression on the face?
   d) What do the gestures mean?
   e) What are the factors influencing this situation? What else is going on? What are they doing? Why are they doing it? How are these factors connected to each other?
   f) In whose interests is it to maintain the problem situation as it is? Who is benefiting from this situation? How are they connected to each other? Do they support each other?
   g) Who will benefit from a change in this situation? How will they benefit?
   h) What are the resources we have to help resolve this problem? Who? Where are they?
   i) What exactly needs to be changed?

10. Some people use special coloured pens for different things. Experiment with the process and invent your own improvements. Consider using the red pen to mark exactly what needs to be changed. Don't use it for anything else. Maybe you can use another colour just to indicate resources to help resolve the problem.
11. At the end, ask a group member to describe the whole picture so that it remains in people's minds as a concrete step in your collective analysis. Make plans to build on this, either to make specific action plans, resolve some contradictions which were indicated, or celebrate everything you have going for you.

Note: Additional Resources — *Working Together for Change: Women's Self Help Handbook*. Vol. 1, pp. 32-35; *A Popular Education Handbook*. pp. 39-42; GATT-FLY. *AH-HAH!* (See Reference List at end of Appendix)

SCULPTURING

Objective:
To analyze the role of the health promoter in relation to the broader health system.

Materials:
A large open space plus paper and markers to name the actors. A polaroid camera is a wonderful addition so that people can see the progression of the sculpture afterwards.

Procedure:
The main actors in the health system were identified during the collective drawing exercise and written on a piece of paper with magic marker so they could be clearly seen.

1. Explain that we will be trying to put the actors in relationship to each other in terms of their relative power over decision making and resources in the health care system in Ontario.
2. Ask for a volunteer to take the first actor, using tape to fasten on the identifying paper. Ask for a volunteer to take the second actor, and position themselves in relation to the first. Ask the group for agreement/changes/suggestions.
3. Proceed with the others, leaving the health promoter until last. Be sure that everyone has an opportunity to voice concerns/disagreements etc. and that the "analysis" is collective.
4. The health promoters (social change agent, burnt out promoter, bandaid etc.) are placed in relation to the rest of the actors. Note that additional health promoters may be identified — with roles inside the system as well as in the community. The discussion here should be intense as we attempt to put ourselves "into the picture".
5. Review the picture, noting the power relationships as you summarize.

Debriefing:
The specific questions you ask may vary depending on what emerged from the sculpture. Some examples: a) In the sculpture, who benefits from the present organization of the health care system? Who loses? b) Whose interests are we promoting in health promotion? Whose do we want to promote? c) What did the sculpture suggest to you in terms of strategy for change?

WHAT NEXT

Look at application of popular education to the work context of participants.

CASE STUDIES

Two participants were asked to prepare a brief presentation on a program which had applied the principles of popular education methodology to health promotion in Toronto.

TWOS

We asked people to discuss with a neighbour one or two ways they could apply popular education methodology in their work. We asked people to share back one idea. This is a very effective tool and ensures that everyone will talk. To prevent long, boring report backs in larger groups, ask the first couple to give you 1 or 2 of their points — and then continue the round, asking for new points only.

REFERENCE LIST

1. *Working Together for Change: Women's Self-Help Handbook*. (Vol. 1, pp. 29-30). The Women's Self-Help Network. Campbell River: Ptarmigan Press. 1984. (1372 Island Highway, Campbell River, B.C., V9W 2E1)
2. Arnold, R. and Burke, B. *A Popular Education Handbook*. Toronto: CUSO Development Education & Ontario Institute for Studies in Education. 1983.
3. Arnold, R., Burke, B., and Barndt, D. *A New Weave: Popular Education in Canada*. Toronto: CUSO Development Education & Ontario Institute for Studies in Education. 1985.
4. GATT-FLY. *AH-HAH! A New Approach To Popular Education*. Toronto: Between the Lines. 1983.
5. *Neighbourhood Action: Recipes for Change*. written and compiled by: Neighbourhood Action, Sticks & Stones and Friends. Sudbury: Acme Printers. 1985.

RESOURCES

Adapted from: *Women's Resource Kit*
Women's Health Education Project
Labrador, Nfld.

Arnold, Rick and Bev Burke. *A Popular Education Handbook: an Educational Experience taken from Central America and adapted to the Canadian Context.* CUSO Development Education and the Ontario Institute for Studies in Education, Adult Education Department. N.d.

Barndt, Deborah, Ferne Cristall and dian marino. *Getting There: Producing Photostories with Immigrant Women.* Between the Lines, Toronto. 1982.

Barndt, Deborah. *Education and Social Change.* Dubuque Iowa: Kendal Hunt. 1980.

Beaucage, Marjorie. (1) *Facilitating Groups* (2) *Community Action Development* (3) *Working with Community Groups (Instructor Guide)* (4) *Working with Community Groups (Trainee Manual).* New Careers Branch, Department of Labour and Manpower, 500-213 Notre Dame Ave., Winnipeg, R3B 1N3. 1983.

Czerny, M. and Swift, J. *Getting Started on Social Analysis in Canada.* Kitchener: Between the Lines. 1984.

Coover, Virginia (and others). *Resource Manual for a Living Revolution.* New Society Publishers, 4722 Baltimore Ave., Philadelphia, PA 19143. 1981.

Freire, Paulo. *Education for Critical Consciousness.* Herder and Herder, New York. 1972.

Gallagher, Anne (and others). *The Helping Hands Puppet Theatre Manual.* Sponsored by Planned Parenthood of Halifax, Dartmouth and Halifax County and funded by Health and Welfare. N.d.

Hall, Budd L. *Creating Knowledge: Breaking the Monopoly: Research Methods: Participation and Development.* Participatory Research Group, Working Paper No. 1, 386 Bloor St. West, Toronto, M5S 1X4. 1976.

Hill, Karen. *Helping You Helps Me: a Guide Book for Self-Help Groups.* Canadian Council on Social Development, P.O. Box 3505, Ottawa, K1Y 4G1. 1984.

Jacobson, Helga. *How to Study Your Own Community: Research from the Perspective of Women.* Women's Research Centre, 301-2515 Burrard Street, Vancouver, B.C., V6J 3J6. 1977.

Judson, Stephanie, compiler and editor. *A Manual on Nonviolence and Children.* Nonviolence and Children, Philadelphia Yearly Meeting, 1515 Cherry St., Philadelphia, PA 19102. 1977.

Kid, Ross. *Coopting Freire: A Critical Analysis of Psuedo-Freirean Adult Education,* in *Economic and Political Weekly,* Vol. XVL, Nos 1 and 2. Bombay, Jan 3-10. 1981.

Labonte, Ronald N. and P. Susan Penfold. *Health Promotion Philosophy: from Victim-Blaming to Social Responsibility.* Health Promotion Directorate, Health and Welfare Canada. 1981.

marino, dian. *Drawing from Action for Action: Drawing and Discussion as a Popular Education Process.* Toronto: Participatory Research Group. 1981.

NiCarthy, Ginny. *Getting Free: a Handbook for Women in Abusive Relationships.* Seal Press, 312 S. Washington, Seattle, Wash. 98104. 1982.

Sleet, David A. and David E. Corbin. *Simulation Gaming in Health Education* from the Handbook of Health Education. Appen Systems, Germantown, Maryland. 1979.

Pfieffer, W.J. and Jones, J.E. *Annual Handbook for Group Facilitators.* Iowa City: University Associates Press (7596 Eads Ave, La Jolla, California, 92037 U.S.A.)

Werner, David and Bill Bower. *Helping Health Workers Learn: a Book of Methods, Aids and Ideas for Instructors at the Village Level.* The Hesperian Foundation, P.O. Box 1692, Palo Alto, Calif. 94302. 1982.

Werner, David. *Where There Is No Doctor: a Village Health Care Handbook.* The Hesperian Foundation, P.O. Box 1692, Palo Alto, Calif. 94302. 1977.

AH-HAH! a New Approach to Popular Education by GATT-Fly. Between the Lines, Toronto. 1983.

Drawing From Action for Action. Drawing and Discussion as a Popular Research Tool. Participatory Research Group, 386 Bloor St. West, Toronto, M5S 1X4. 1981.

Handbook on the Use of Simulation Exercises and Board Games. NFE Training Materials, University of Botswana and Swaziland, Division of Extra-Mural Services. 1977.

It's Just Your Nerves; a Resource on Women's Use of Minor Tranquillizers and Alcohol. Health and Welfare Canada. N.d.

Let Us Learn Together. Centre for Popular Education, Ministry of Education, Free Grenada. 1980.

My Machine's Broken Down. A song sung by workers about the workplace. N.d.

The Native Woman; Existing or Living. B.C. Native Women's Society, 116 Seymour St., Kamloops, B.C. 1982.

Organizing Macro-Analysis Seminars: Study and Action for a New Society. New Society Publishers, 4722 Baltimore Ave., Philadelphia, PPA 19143. 1981.

Participatory Research: Developments and Issues from *Convergence*, an International Journal of Adult Education, vol. 14, no. 3. P.O. Box 250., Sta. F, Toronto, M4Y 2L5. 1981.

People Working with People Monograph Series. Guide booklets covering aspects of human resource development, University of Guelph, Guelph, Ontario, N1G 2W1.

Prime Time Information Kit. Booklets (12) produced during a project for Women in their Middle Years. Sponsored by the B.C. Assoc. of Social Workers and Y.M./Y.W.C.A., Victoria and funded by Health and Welfare Canada. 1977-80.

Social Animation: a Course on Leadership and Group Work Skills. Designed by Women Working with Immigrant Women, the Cross-Cultural Community Centre and the Participatory Research Group. 1980.

Working Collectively by the Women's Self-Help Network. Ptarmigan Press, 1372 Island Highway, Campbell River, B.C. V9W 2E1. 1984.

Working Together for Change; Women's Self-Help Handbook (vols. 1 and 2 and a Training Manual) by The Women's Self-Help Network. Ptarmigan Press, 1372 Island Highway, Campbell River, B.C. V9W 2E1. 1984.

WORKSHOP PARTICIPANTS

Ms. Tracey Allan-Koester
1508-211 Sherobee Road
Mississauga ON
L5A 2H5

Ms. Ruth Armstrong
242 Kenilworth Avenue
Toronto ON
M4L 3S6

Ms. Sherry Barton-Schmidt
City of Toronto
Public Health Department
Prevention Section
4th Floor, East Tower
Toronto M5H 2N2

Ms. Elaine Berman
CUSO Coordinator
CUSO
C/o International Centre
Queen's University
Kingston ON
K7L 3N6

Mr. Eric Boss
Peel Regional Health Unit
Environmental Health Division
10 Peel Centre Drive
Brampton ON
L6T 4B9

Ms. Diane Bourgeois
Transport Canada
Program Manager, Occupational Health
Tower C, Place De Ville
Ottawa ON
K1A 0N8

Ms. Carol Brehaut
Faculty of Nursing
University of Toronto
50 St. George Street
Toronto ON
M5S 1A1

Ms. Cathy Campbell
University of Toronto
Assistant Professor
Dept. of Nutritional Services
Faculty of Medicine
Fitzgerald Bldg.
Toronto ON
M5S 1A8

Ms. Carmen Connolly
Program Coordinator
Department of Nutritional Sciences
University of Toronto
150 College Street
Toronto ON
M5S 1A8

Mrs. Rosemary Coombs
2082 Black Friars Road
Ottawa ON
K2A 2K4

Ms. Nancy Craig
3 Johnson Road
Aurora ON
L4G 2A1

Ms. Paula Dallosto
Peel Regional Health Unit
10 Peel Centre Drive
Brampton ON
L6T 4B9

Ms. Lynda Davies
President
Education Wife Assault
427 Bloor Street West
Toronto ON
M5S 1X7

Ms. Barb Davis
141 Kennedy Street W
Aurora ON
L4G 2L8

Ms. Denise DeRape-Bridge
Health Educator
North York Public Health Department
5100 Yonge Street
North York ON
M2N 5V7

Ms. Rhoda Dickson
RHN
Northwestern Health Unit
704 Church Street
Fort Francis ON
P9A 1E1

Ms. Norma Drummond
Community Health Officer
Department of Public Health
815 Danforth Avenue, 2nd Floor
Toronto ON
M4J 1L2

Mrs. Jeanie Fo
Board Member
Lakeshore Area
Multi Service
49 Fifth Street
Toronto ON
M8V 2X1

Mrs. D'Arcy Farrow
2nd Stanley Drive
Waterloo ON
N2L 1H9

Ms. Nancy Fisher
Manager, Educational Services
Heart and Stroke Foundation
521 Otto M. Street
Toronto ON
M4Y 2S1

Ms. Peg Folsom
North York Health Unit
5100 Yonge Street
North York ON
M2N 5V7

Ms. Denise Gaulin
RHN
City of Etobicoke
Health Department
399 The West Mall
Etobicoke ON
M9C 2Y2

Ms. Joanne Gilmore
3339 Council Ring Road
Unit 9
Mississauga ON
L5L 2A9

Mr. Ann Goldblatt
Community Health Officer
City of Toronto
Department of Public Health
555 Jarvis Street
Toronto ON
M4Y 2G1

Ms. Rita Goldenberg
Seneca College
1 Forest Laneway, M 304
Willowdale ON
M2N 5Y8

Ms. Mary Graham
Apt. 503
11 Walmer Road
Toronto ON
M5R 2W9

Ms. Helen Heaney
Supervisor
The Sunnymede Hospital
2 Glen Agar Drive
Etobicoke ON
M9R 4L1

Dr. Mary Heiberg
Regent Park Community Health Centre
14 Pelham Place
Toronto ON
M5A 3H4

Mr. Dennis Heughan
Davenport and Perth Neighbourhood
Centre
324 Bathurst Avenue
Toronto ON
M5T 2R7

Ms. Jessica Hill
Policy Program Analyst
Health and Welfare Canada
Health Services and Promotion Branch
102 Bloor Street West
Suite 410
Toronto ON
M5S 1M8

Mr. John Hoyes
Senior Advisor in Health Education
Health Education, Promotion Unit
Ministry of Health
8th Floor, Hepburn Block
Queen's Park
Toronto ON
M7A 1R2

Ms. M. Kellam
Primary Care Nurse
South Riverdale Community Health Centre
124 Pape Avenue
Toronto ON
M4M 2Y8

Ms. Catherine Knipe
Health Educator
Simcoe County District Health Unit
Administration Centre
Midhurst ON
L0L 1X0

Ms. Janice K. Kopinak
PHN
Regional Municipality of Waterloo
850 King Street West
Kitchener ON
N2G 1E8

Ms. Marjorie Kort
Health Educator
460D Edgeworth Avenue
Ottawa ON
K2B 5L1

Ms. Laura Kropp
CUSO
C/o International Centre
Queen's University
Kingston ON
K7L 3N6

Ms. Karen Kurtzrock
1036 Shaw Street
Toronto ON
M6G 3N3

Mr. Ron Labonte
Department of Public Health
City of Toronto
7th Floor East Tower
City Hall, 100 Queen Street
Toronto ON
M5H 2N2

Ms. Roslyn Levy
PHN
City of Toronto
Northern Health Area
64 Merton Street
Toronto ON
M4S 1A1

Mrs. Jean Lilley
City of Toronto
Department of Public Health
Eastern Health Area
1631 Queen Street East
Toronto ON
M4L 1G4

Ms. Brenda Little
PHN
Hamilton Wentworth Regional
Health Unit
26 Highcliffe Avenue
Hamilton ON
L8A 3L4

Ms. Jean Love
Ministry of Health
Communications Branch
Hepburn Block
Queen's Park
Toronto ON
M7A 1R3

Ms. Jane MacDonald
International Development
Research Centre
Box 8500
Ottawa ON
K1G 3H9

Ms. Elizabeth MacNeil
PHN
Kingston, Frontenac, Lennox and Addington
Health Unit
221 Portsmouth Avenue
Kingston ON
K7M 1V5

Dr. Isabel MacRae
Professor of Nursing
University of Toronto
Faculty of Nursing
50 St. George Street
Toronto ON
M5S 1A1

Ms. Nancy Maich
Mohawk College Healthline
Corporate Health Services
48 Fieldgate Drive
Brantford ON
N3P 1H3

Ms. Magaret Malone
25 Maybelle Avenue
#3004
Islington ON
M9A 4Y1

Ms. Joan Martino
North York Health Unit
5100 Yonge Street
Toronto ON
M2N 5V7

Mrs. Marg Metzger
Assistant Manager, Educational Services
Heart and Stroke Foundation
574 Church Street
Toronto ON
M4Y 2S1

Ms. Michele Michaud
Acting Nursing Supervisor
Halton Regional Health
Department
1151 Bronte Road, P O Box 7000
Oakville ON
L6J 4E1

Ms. Sheryl Mitchell
55 Roxborough Street West
Toronto ON
M5R 1T5

Ms. Judy Murray
PHN Supervisor
Dept. of Health Services
Durham Region
301 Golf Street
Oshawa ON
L1G 4B2

Ms. Janice Murray
Coordinator, Employer Awards Program
for Health Promotion
5th Floor, 15 Overlea Blvd.
Ministry of Health
Toronto ON
M4H 1A9

Ms. Janet Murray
CUSO: Community Development Worker
c/o Talbot College
#434 UWO
London ON

Ms. Maryan O'Hagar
563 Fraser Avenue
Ottawa ON
K2A 2R3

Mrs. Pat Ouchterlony
63 Lascelles Blvd.
Toronto ON
M5P 2E3

Ms. Iris Page
North York Public Health Department
5100 Yonge Street
North York ON
M2N 5V7

Ms. Harriet Parr
20 Frank Crescent
Toronto ON
M4G 3K5

Ms. Margaret Prior
Public Health Nurse
York Centre for Health
504 Oakwood Avenue
Toronto ON
M6E 2Y1

Ms. Cathy Quick
PHN
Hamilton Wentworth Regional
Health Unit
26 Highcliffe Avenue
Hamilton ON
L8A 3L4

Ms. Heather Ramsey
Health and Welfare Canada
Policy and Program Analysis
Services and Promotion Branch
102 Bloor Street West
Suite 410
Toronto ON
M5S 1M8

Dr. Michael Roberts
Lawrence Heights Community
Medical Centre
3 Replin Road
Toronto ON
M6A 2M8

Ms. Lynn Roblin
Public Health Nutritionist
North York Public Health
Department
5160 Yonge Street
North York ON
M2N 5V7

Mr. Bill Rooney
Social worker to
Elderly-Handicapped
Dalhousie Health & Community
Service Centre
755 Somerset Street W
Ottawa ON
K1R 6R1

Ms. Peggy Schultz
Canadian Mental Health Association
Ontario Division
56 Wellesley Street W
Toronto ON
M5S 2S3

Ms. Elizabeth Shantz
Nursing Supervisor
Durham Region
Department of Health Services
Ajax Office
126 Commercial Avenue
Ajax ON
L1S 2H5

Ms. Michelle Shrott
Public Health Nutritionist
East York Health Unit
550 Mortimer Avenue
Toronto ON
M4J 2H2

Ms. Christine Sisson
394 Wilson Avenue
Apt. 5
Downsview ON
M3H 1C7

Ms. Kate Slater
2 Canham Crescent
Scarborough ON
M1S 2H6

Ms. Heather Snell
Director of Education
Muscular Dystrophy Association of Canada
150 Eglinton Avenue East
Suite 400
Toronto ON
M4P 1E8

Ms. Ellen M. Souter
Community Educator
Family Planning Program
Hamilton-Wentworth Department of
Health Services
25 Main Street, P O Box 897
Hamilton ON
L8N 3P6

Ms. Alison Stirling
Community Health Educator
Parkdale Community Health Centre
1257 Queen Street West
Toronto ON
M6K 1K5

Ms. Gunta Sturis-Sture
2575 Danforth Avenue
1809
Toronto ON
M4C 1L5

Ms. Judy Sullivan
120 Chandos Avenue
Toronto ON
M6H 2E8

Ms. Beth Swart
RR #1
Uxbridge ON
L0C 1K0

Ms. Mary Anne Tangney
Community Health Nurse
Hamilton-General Hospital
237 Barton Street East
Hamilton ON
L8P 3X2

Ms. Cheryl Teeter
Health Education Nurse
Dalhousie Health and Community Services
755 Somerset Street West
Ottawa ON
K1R 6R1

Dr. John Thompson
CUSO
Talbot College
Room 434
University of Western Ontario
London ON

Mr. Lori Turick
North York Dept. of Health
5 Fairview Mall
Suite 470
Willowdale ON
M2J 2Z1

Ms. Linda Ward
Public Health Nurse
East York Health Unit
550 Mortimer Avenue
Toronto ON
M4J 2H2

Ms. Gayle Warman
Perth District Health Unit
653 West Gore Street
Stratford ON
N5A 1L4

Ms. Marnie Weller
Dalhousie Health Community Centre
755 Somerset Street west
Ottawa ON
K1R 6R1

Ms. Jennifer Welsh
Chair, Department Food & Nutrition
Ryerson Polytechnical Institute
350 Victoria Street
Toronto ON
M5B 2E8

Ms. Debbie Zanetti
Supervisor of Dental Education
City of North York
5100 Yonge Street
North York ON
M2N 5V7