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Empowering Health Promotion

A Holistic Approach in Preventing Sexually Transmitted Infections Among First Nations and Inuit Adolescents in Canada

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Sexually transmitted infections (STIs) such as gonorrhea and chlamydia, among others, are significant health concerns for Canadian aboriginal (i.e., First Nations, Inuit) adolescents. This is further compounded by ineffective prevention and promotion strategies that were designed to lessen the incidence of STIs in this population. Structure and content of health service programs are crucial considerations in STI prevention because even well-constructed and carefully implemented programs may have very little impact on aboriginal youth if these programs are not culturally sensitive and specific to individual adolescent’s needs. Furthermore, because components of sexual and reproductive health are inextricably linked to empowerment and equality between the sexes, holistic health nurses need to develop strategies that increase self-esteem, self-advocacy, and healthy choices among aboriginal adolescents.

Keywords: empowerment; sexually transmitted infections; aboriginal health; reproductive health; community health promotion

Sexually transmitted infections (STIs) like chlamydia and gonorrhea remain an ever-present threat to the general health, well-being, and reproductive capacity of many people (Alary, 1997; Patrick, 1997). In North America, chlamydia infections are known to be 3 to 5 times more prevalent than any other STI (Health Canada, 2001; Patrick, 1997). After chlamydia, gonorrhea is the second most commonly
reported bacterial STI (Alary, 1997). If untreated, both chlamydia and gonorrhea may result in serious consequences, especially for women. These include pelvic inflammatory disease (PID), chronic pelvic pain, tubal infertility, and ectopic pregnancies (Health Canada, 2001).

In Canada, reported rates of chlamydia and gonorrhea are highest among aboriginal (First Nations, Inuit) adolescents, and in some regions (Nunavut, Northwest Territories), chlamydia and gonorrhea rates were reported to be more than 10 times the national average (Health Canada, 2001). The prevention of STIs and their negative health, social, and economic consequences for aboriginal adolescents has recently become a central goal for many community-based health programs. The issue is not, however, whether these programs should be provided, but what type of interventions and health promotion strategies will be most effective to bring about the desired goals (Aral, 2000; Health Canada, 2001; Kaufert & Kaufert, 1998).

The purpose of this article is to outline strategies that may assist holistic health nurses in delivering health education to aboriginal youth (First Nations, Inuit) concerning the prevention of STIs. Such strategies include participatory action research (PAR), the use of peer leaders, and the development of self-advocacy skills. These health education strategies are presented within the overarching framework of empowering health promotion.

**EMPOWERING HEALTH PROMOTION**

Health education is a component of health promotion and, when used appropriately, “health promotion is our most effective tool in the prevention of STIs” (Wardrop, 1993, p. 9). Health promotion projects and programs should function across sectoral lines fostering full community involvement and ensuring continuous development of appropriate technology and resources for accomplishing health goals (World Health Organization, 1978). By using health promotion as a framework for safer sexual practices, nurses can foster a multifaceted approach to STI prevention that includes not only approaches like education, but also community development, mass communication, self-help, public policy development, and organizational change. Holistic health nurses, whose educational efforts are focused on such a framework for STI prevention, will be able to develop creative applications and seek improved interventions (Wardrop, 1993).
Health promotion entails both personal and community empowerment. Personal empowerment is an internal process that entails self-efficacy, personal competence, and a willingness to take action in the public domain (Wallerstein, 1992). Classical health-promotion pedagogy has often disempowered people by assuming that they are only capable of acquiring knowledge, not producing it (Freire, 1970, 1973). Hence, social scientists and health care providers working in aboriginal communities have often made the mistake of imposing an agenda that they have developed in isolation of the learner population. In most cases, health care providers did not consult the community about their ideas regarding what will work, creating a complete dismissal of the community intelligence (Neighbors, Braithwaite, & Thompson, 1995). Freire (1970) advocated an alternate approach in which people are not objects or recipients of political and educational projects but actors in history who are able to identify their community problems and the necessary solutions to transform themselves while changing oppressive circumstances. Freire advanced a concept of conscientization that provides a foundation for linking individual, organizational, and societal levels of the social system. Conscientization involves the development of a sense of identification within a group and a sense of collective efficacy. Through a dialectical process of collective reflection and action, individuals, organizations, and the community at large develop the capacity to act effectively to create social change.

Although classical health-promotion approaches such as lectures and group discussions developed without learner input may have some benefits to select learners, they have limited application when the learners are coping with collective despair and frustration, common outcomes of poverty, substance abuse, violence, and other public health problems that are typically seen in many aboriginal communities (Freire, 1970; Neighbors et al., 1995). Health education interventions should, therefore, be judged in terms of their ability to strengthen local authority and to legitimize the abilities of the local self-help group or community. Neighbors and colleagues stated, “It is impossible to produce health among the powerless. It is possible, however, to allow health by transferring the tools, authority and income to those with the malady of powerlessness” (p. 285).

Working together with aboriginal youth to address the psycho-social issues affecting their health and STI prevention is one way for holistic health nurses to develop a health care system that is account-
able to the community for the adolescents’ health needs. Nurses are now being actively encouraged to promote the inclusion of youth in all aspects of decision making regarding health education designed to meet adolescents’ needs (Bushnell & Cook, 1995). Personal development is the key to this process. It draws on existing human and material resources in the community to enhance self-help and social support and to develop flexible systems for strengthening public participation and direction of health matters (Wardrop, 1993). Community development, an extension of the principles of personal development in the larger community, involves community members in a process to (a) identify issues and problems affecting their community; (b) develop plans, skills, and capabilities to act on common concerns; (c) determine what resources are available; and (d) implement plans for change (Wardrop, 1993).

Community development requires a different way of looking at things. A significant challenge to holistic health nurses and other health professionals who are attempting to incorporate the principles of community development is that they are now asked to give up control to the community with whom they are working and to abandon preconceived ideas about the best way to implement a project (i.e., sexual health) or the expected outcomes of a particular health education program (i.e., prevention of STIs). For example, when helping youth overcome high-risk behaviors that may lead to STIs, holistic health nurses could facilitate group discussions and communication around STIs and encourage the youth members to come up with realistic solutions. This example of practice, however, is contrary to the socialization occurring in most traditional health care education programs, which emphasize the practitioner’s sole authority in problem definition and problem management in health education program planning and implementation (Wardrop, 1993).

**Participatory Action Research**

One approach that may be used to involve aboriginal youth in developing and evaluating health education programs that are designed to meet their unique needs to control STIs is PAR (Barlow et al., 1998; O’Neil & Commanda, 1998; O’Neil, Reading, & Leader, 1998). PAR usually involves the following: (a) some form of collaboration between the researchers and the researched, (b) a reciprocal process in which both parties educate one another, and (c) a focus on the
production of local knowledge to improve interventions or professional practices (Macaulay et al., 1998). The ultimate aim of PAR is to empower research participants to assume ownership of the research process and to use the results to improve their quality of life. Aboriginal people’s experience with research has not always been positive. Frustrated with decades of externally controlled research agendas, community members are becoming more insistent that all forms of research be developed in full partnership with aboriginal organizations and communities (Health & Welfare Canada, 1998). In the Kahnawake Schools Diabetes Prevention Project (Mohawk Nation, Canada), for example, the elected community project members retained control of the research data, had the right to approve publication (or provide a dissenting opinion), but also had obligations to their scientist partners to provide an opportunity for continuing data analysis and publication (Health Canada, 2001). Fundamental to PAR is the breaking down of the distinction between researcher and participants to build collaboration between the parties (Macaulay et al., 1998).

There are many advantages to involving beneficiaries in research and in the development of health promotion programs. For example, the relevance of the research questions and data collection methods agreed to by participants are more likely to be accepted by the study participants and, thus, lead to useful results for the target community. Involving participants in interpretation of the results usually brings richer contextual information and increasingly meaningful conclusions. Furthermore, community ownership of data, both during and after the research process, prevents potential misuse of the results. In addition, managing dissent at the time of publication is an innovative feature that provides a framework for discussion and negotiation and aims to avoid extreme solutions and unresolved disagreements (Macaulay et al., 1998). More important, however, is the fact that participatory research becomes meaningful to the community because it allows the latter to claim ownership of and internalize the research findings increasing the likelihood that research results will have long-lasting impact (Allman, Meyer, & Cockerill, 1997). At the opposite end of the scale, PAR can also be a very challenging and tedious process. Due to the nature of PAR, scientists employing this research methodology are not only taking a risk against the unknown but are embarking on a path of numerous unforeseen frustrations and challenges. These may include unmet deadlines, cost restraints, disagreement among participants, or having the community veto the research
at the time of publication (Macaulay et al., 1998). In most situations, PAR is limited to projects that do not have time constraints or limited funding. In these instances, a more conventional form of research may be warranted (Allman et al., 1997; Macaulay et al., 1998). Furthermore, very little research has been done to validate the efficacy of PAR in community-based health initiatives like STI prevention strategies among Canadian aboriginal youth.

**Peer Education by Peer Leaders**

A growing body of evidence indicates that behavioral interventions can reduce STI risk-associated sexual behavior for adolescents (Aral, 2000). Determinants that have been found to be salient factors in STI prevention include self-efficacy, behavioral beliefs, outcome expectancies, subjective norms, vulnerability, and susceptibility. Various approaches have been used to affect these factors and to change risky sexual behavior. One such approach is the use of peer educators (Villarruel, Sweet-Jemmott, Howard, Taylor, & Bush, 1998).

Adolescent peer educators play key roles in many community-based STI risk-reduction programs for youth including those directed toward out-of-school or hard-to-reach youth (O’Hara, Messick, Fichtner, & Parris, 1996). There is a wealth of information about the effect of peer educators on adolescent sexual beliefs and behaviors including their impact on early sexual activity, abstinence, and other self-protective behaviors (Guthrie et al., 1996; O’Hara et al., 1996). Peer referent groups serve adolescents as a repository of norms, values, preferences, knowledge, and behaviors that support safer sex behaviors (Guthrie et al., 1996). Thus, peer-led approaches aimed at modifying STI risk-related behaviors and unwanted pregnancies are both natural and potent interventions for encouraging adolescents to engage in self-protective sexual behaviors such as abstinence.

Prevention services that employ adolescent outreach workers who closely reflect target clients in terms of age, ethnicity, language spoken, and experience have proven effective in a number of areas. Among these are distribution of STI-related information, accurate data collection, program planning, and modification of relevant norms and behaviors among out-of-school youth and street-based populations. Role playing, dramatization of realistic situations, and short skits depicting common situations in which adolescents find themselves can serve as teachable moments for shared life skills such
as assertiveness, decision making, and values awareness. It has also been established that for health promotion programs to effectively modify behaviors of high-risk youth, their designs should include messages delivered by individuals who have shared similar life experiences (Villarruel et al., 1998).

Similar life experience is one of many criteria used to select suitable peer educators. Other criteria may include an eagerness and ability to learn and disseminate health information; dependability; communication style; confidence; approachability; sensitivity to issues related to STIs, pregnancy, and sexual abuse; and confidentiality. Peer educators are often recommended by their own peers, other peer educators, teachers, or community members due to their charisma, willingness to help others, or because of their role model ability (Villarruel et al., 1998).

Despite evidence to support the effectiveness of adolescent peer educators in STI risk-reduction interventions, there is little research that describes the STI knowledge, beliefs, and behaviors of aboriginal peer educators (Villarruel et al., 1998). Comprehensive training for aboriginal peer educators would, therefore, be strongly recommended, especially when dealing with sensitive issues like STI prevention. Furthermore, training should address adequate knowledge on sexual/reproductive health and foster healthy beliefs, skills, and behaviors regarding the prevention of STI infections among their peers.

DEVELOPING SELF-ADVOCACY

Enhancing self-advocacy skills among aboriginal adolescents is another strategy that may be used to prevent STI infections. Self-advocacy is the ability to seek, evaluate, and use information to promote one’s own health. Self-advocacy is often a product of an individual’s sociocultural orientation, which refers to the learned ways of doing, feeling, and thinking both in the past and in the present as well as religious beliefs, family values, rituals, and language. Adolescents’ sociocultural orientations are often transmitted from family members, friends, community members, and the mass media. These outside influences help shape attitudes toward health, life skills, self-advocacy, and self-concept. Adolescents who come from present-oriented cultures (i.e., Inuit and First Nations People) rather than future-oriented cultures will tend to have more difficulty in making
immediate choices that will affect their future health. Many aboriginal languages, for example, do not even contain past and future tenses. As a result, individuals who regularly use aboriginal languages are likely to focus on the present rather than long-term consequences of health behavior. This is different from the focus of adolescents whose native language is English, a language that emphasizes time and numeric order (Vessey & Sloand-Miola, 1997).

The socioeconomic status of adolescents’ families is also an important consideration in determining an individual’s self-advocacy. Socioeconomic status goes beyond financial resources to reflect educational background as well. Higher socioeconomic status provides adolescents with a sense of entitlement not often seen in teens from poorer families; they expect to accomplish more and receive more during their lives. Because of this, adolescents from higher socioeconomic backgrounds will learn self-advocacy more rapidly. Adolescents from lower socioeconomic backgrounds may have less motivation for behavior change because they have less sense of their future and their control of it (Vessey & Sloand-Miola, 1997).

Self-advocacy health education programs must address a number of requirements of self-advocacy such as motivation, self-esteem, and developmental maturity. Motivation is the force that moves a person toward a specific action (Sinnema, 1991). It can be intrinsic, coming from within, or extrinsic, coming from such external forces as parent or peer interaction and the promise of rewards or the threat of punishment. Both external and internal motivating factors can play a role in changing an adolescent’s health behavior (Vessey & Sloand-Miola, 1997). Motivation is often influenced by the interplay of personality traits, developmental level, knowledge, sociocultural background, and previous experiences. Adolescents who perceive benefits from engaging in self-advocacy behaviors are more apt to take action.

Adolescents who have perceptions of self-efficacy and have mastered a variety of physical, intellectual, social, and emotional tasks will have a tendency to engage in self-advocacy more readily than adolescents with vulnerable personalities (Sinnema, 1991; Vessey & Sloand-Miola, 1997). Primary care is needed to identify adolescents with behavioral patterns related to disturbances in body image, self-image, or self-esteem (Vessey & Sloand-Miola, 1997). Approaches such as using dialogue or figure drawings may help detect aboriginal adolescents at risk for negative self-image, eating disorders, or sexual identity disturbance (Doswell, Millor, Thompson, & Braxter, 1998).
To help aboriginal adolescents develop self-advocacy, holistic health nurses must have the knowledge and ability necessary to teach these skills. Nurses need to recognize each adolescent’s potential, avoid stereotyping, and attend to cultural nuances. Self-advocacy is taught, in part, by example, and nurses can emulate advocacy by modeling advocacy skills in front of the adolescent (Vessey & Sloand-Miola, 1997).

Holistic health nurses can also help adolescents become appropriately assertive by teaching them to ask for information and to make decisions about their own care. Paternalism, revealed in the attitude of “I’ll tell you what you need to know” or “Don’t worry, I’ll take care of it,” sends a message to adolescents that their questions are unimportant or that they are incapable of claiming ownership of their lives (Vessey & Sloand-Miola, 1997). Role-playing, learning to use “I” statements, teaching negotiation skills, and making health educational materials accessible can help adolescents learn to recognize their problems and share them with their parents and other health care providers. The prevailing goal in self-advocacy programs is to use every opportunity to encourage adolescents to take charge of their bodies and their health (Vessey & Sloand-Miola, 1997).

Other aspects of self-advocacy health promotion programs may include presenting preadolescents with a healthy picture of adulthood, the appropriateness of maintaining sexual abstinence, and the physiology of puberty in pubertal developmental transition. Presentation of this information can be accomplished through focus groups or small group chat sessions enhanced by literature, guest speakers, videos, and computer simulation games and programs (Doswell & Vandestienne, 1996). Furthermore, the nurse should monitor preadolescents’ physical development as they advance through pubertal stages of development. Specifically, the nurse should watch for signs and symptoms of high stress, poor coping, and devaluation of self as well as whether the adolescents are entering transitional social environments such as junior or senior high school. Additionally, signs of sexual abuse should be assessed and reported (Doswell et al., 1998).

Despite the good intentions associated with self-advocacy programs, some adolescents will refuse or are just unable to actively or passively engage in self-advocacy behaviors (Vessey & Sloand-Miola, 1997). If knowledge is limited, the nurse may have to determine if the problem is due to a lack of experience, lack of capacity, or lack of interest. If the adolescent lacks experience, then educational reinforcement
would be warranted. If there is a lack of emotional or cognitive capacity it may be necessary to evaluate family life, social support networks, and community service agencies. Dealing with adolescents who simply lack the interest in developing self-advocacy is perhaps the worst scenario the nurse may encounter and exploring their underlying motivation is a time consuming and difficult process. However, this extra effort is necessary if self-advocacy is to be achieved (Vessey & Sloand-Miola, 1997).

CONCLUSIONS

Health promotion and community development in STI prevention mean different things to different people. To some, community development/health promotion is a project in which particular individuals or groups work on issues central to them (Health & Welfare Canada, 1998; Waldram, Herring, & Young, 1995). To others, it is a process of supporting individuals and groups in their discovery of their own power (Wallerstein, 1992; Wardrop, 1993). To many, it is a philosophy acknowledging the capacity of people to solve their own problems (Freire, 1970; Neighbors et al., 1995). Above all, community development is a commitment by the health worker and the members of the community to a more equitable sharing of life’s resources.

Critics of empowerment and community development in STI prevention among aboriginal youth may dismiss this idealism as soft, but this is not so. Researchers are continually demonstrating that participating in democratic social actions improves mental well-being and personal satisfaction validating what community organizers have intuitively known for decades (Health & Welfare Canada, 1998; Neighbors et al., 1995; World Health Organization, 1978). Still, those who practice empowerment must continually combine the idealism of community with persisting social and economic conditions that foster fear, inequality, and poor health (Health & Welfare Canada, 1998).

Altering structural power inequalities is an important facet of empowerment and health promotion, especially in STI prevention. It requires critical analyses of power in at least three dimensions: power over (oppression), power with (collaboration), and power within (empowerment) (Freire, 1970; Health & Welfare Canada, 1998). It demands that nurses align with and support less powerful groups
Empowerment health promotion in STI prevention demands tolerance because its practice moves between conflict and caring, struggle and support (Health & Welfare Canada, 1998). Furthermore, empowering health practitioners should not abandon the Band-Aid measures of direct client care but ensure that all health services are applied with dignity and cultural sensitivity. In other words, they should not describe the wound only in the language of experts (e.g., STIs, cancer, smoking) but strive to express it in words used by the aboriginal people to describe their own lives and living conditions (powerlessness, poverty, and so on) (Maticka-Tyndale, 1997). Secondly, there are organizational actions. Individuals are conditioned by the social structures in which they exist and only organized actions to alter structural conditions will prevent them from recurring (Maticka-Tyndale, 1997).

To collaborate effectively with aboriginal youth regarding STI prevention, holistic health nurses must be clear on their own ideals of health promotion and be empathetic to how others define their ideals to reach a strategic consensus, especially when issues around language barriers and cultural norms are in effect. Nurses must also be aware of power relations in both their good (empowering) and bad (oppressing) senses (Health & Welfare Canada, 1998). Conflict can be a healthy part of empowerment health promotion. Defining the limits of this conflict (i.e., knowing when it moves from healthy to unhealthy) is just one of the ambiguous issues with which holistic health nurses and their communities must struggle.

REFERENCES


