A Community of Practice Approach for Aboriginal Girls' Sexual Health Education

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Abstract

Introduction: There is a paucity of intervention programs for Aboriginal girls and many of those that exist are delivered in culturally inappropriate ways. **Methods:** In this paper, we provide an overview of recent research that focused on delivering a sexual health mentorship program that enhanced the voices of Aboriginal youth and was culturally relevant and appropriate to indigenous youth. **Results:** Our program served to enhance social connection and reinforced a sense of belonging and relational mutuality among group members. **Conclusion:** The purpose of this article is to illustrate how a mentorship program that used a community of practice approach empowered Aboriginal youth to become successful border crossers and helped to align them with the wider community.

Key words: Aboriginal, girls' sexual health, education

Résumé

Introduction: Les programmes d'intervention pour les adolescentes autochtones sont rares et ceux qui existent ne respectent pas les aspects culturels de cette communauté. **Méthodologie:** Nous donnons une vue d'ensemble des plus récents travaux de recherche axés sur la mise en place d'un programme de mentorat en matière de santé sexuelle qui donne la parole aux adolescentes autochtones et est adapté à leur culture. **Résultats:** Notre programme a permis de renforcer la cohésion sociale, le sentiment d'appartenance et les liens entre les membres du groupe. **Conclusion:** L'objectif du présent article est de montrer en quoi un programme communautaire de mentorat axé sur la pratique aide les jeunes autochtones à sortir de leur communauté et à s'aligner sur la communauté en général.

Mots clés: aborigène, adolescentes, santé sexuelle, éducation

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Introduction

There is a paucity of intervention programs for Aboriginal girls and many of those that exist are delivered in culturally inappropriate ways. The lack of success of mental health programs, for example, has been attributed to the "lack of Aboriginal participation, which could make programs culturally meaningful and locally more relevant" (Kirmayer, Simpson, & Cargo, 2003, p. S21). As described by First Nations people, healing results from interdependence and not from independence (McCormick, 1997b). In this paper, we provide an overview of recent research that focused on delivering a sexual health mentorship program that enhanced the voices of Aboriginal youth and was culturally relevant and appropriate to indigenous youth. In particular, our investigation demonstrates health education approaches that enhanced social connection between Aboriginal girls and their community and were reported by them as being successful in terms of improving Aboriginal adolescent sexual health.

This community-based study used a respectful and participatory approach based on principles of feminist ways of knowing and a community of practice model. We used a feminist research approach because it is voice-centered and based on listening to women's stories and experiences (Way, 2001). A community of practice (Smith, 2005) is a social unit that has a common purpose. "Members interact regularly, share common beliefs and vocabulary and learn from one another as they engage in mutual activities" (Richards, 2006. p. 3), including expert and novice members. Experts then foster novices' growth in understanding. Communities of practice models "offer rich contexts for learning and development" (Richards, 2006, p. 3). Features of communities of practice include mutuality and reciprocity between members, a shared sense of belonging, and the production of common repertoires such as artifacts or routines (Wenger, 1998). The purpose of this article is to illustrate how a mentorship program that used a community of practice approach empowered Aboriginal youth to become successful border crossers and helped to align them with the wider community. Border crossing includes productive dialogue in which space is created for challenging dominant social relations and practices that obliterate the voice of "other" (Friere, 1985).

Adolescent girls' sexual health issues

Adolescent girls face a number of serious health issues related to sexuality and relationships. Unplanned pregnancy, HIV/AIDS and sexually transmitted diseases (STD's) are a major public health concern (Health Canada, 2002). In the US, The Centers for Disease Control and Prevention (CDC) (2004) identified risky sexual behaviour as one of six health behaviours most associated with mortality, morbidity, and social problems among youth. Conflicting social pressures continue to affect adolescents' abilities to make decisions about contraceptive use and safe sex and contribute to risk-taking behaviours in heterosexual intimate relationships. For example, Hutchinson (1998) found that for 59% of adolescent girls, sexual risk history was not discussed with their partners prior to having sexual relations for the first time.

Aboriginal adolescent girls' sexual health issues

While the general adolescent population is already at risk for poor health, the health problems are even more pronounced in Aboriginal communities. This disparity is particularly obvious in areas concerning adolescent sexual/dating health issues including risky alcohol use/sexual activity and risk for Fetal Alcohol Spectrum Disorders (FASD); unplanned pregnancy; and contacting sexually transmitted diseases (STD's), namely AIDS, gonorrhea and chlamydia (Health Canada, 2001). Aboriginal people are being infected with HIV at a younger age compared to non-Aboriginal persons (Public Health Agency of Canada, 2004). Furthermore, higher levels of psychological distress among Aboriginal youth are reported as being associated with younger age, female sex, early loss of parents or a relative, and a smaller social network – or fewer than five close friends or relatives (Kirmayer, Simpson & Cargo, 2003). Joining communities effectively will expand individuals' social networks. In Canada, Aboriginal peoples (First Nations, Inuit, and Metis) make up 2.8% of the total population with approximately 60% of the population younger than age 30 (Health Canada, 2002).

Even though in Canada advancements are being made in health services delivery specific for Aboriginal adolescent women, significant inequities remain in relation to the general population (Health Canada, 1999). One reason for the higher incidence of sexual health issues among such women is the incongruency between Western medical approaches (based on a biomedical framework of disease, treatment and prevention), and approaches that are more holistic and culturally sensitive (Van Uchelen, Davidson, Quressette, Brasfield, & Demerais, 1997). Western values and individualistic views serve to isolate the adolescent at a time when connections take on greater meaning (Banister & Begoray, 2006). Furthermore, cultural discontinuity and oppression, and marginalization have been linked to high rates of depression, alcoholism, suicide, and violence in many communities, with the greatest impact on youth (Kirmayer, Brass & Tait, 2000). Chandler and Lalonde (1998) argue, for example, that cultural discontinuity is strongly associated with suicide risk for Aboriginal youth.

Intervention programs for Aboriginal youth

There is a lack of research on sexual health education specifically targeted to Aboriginal populations and particularly pertaining to Aboriginal youth (Majumdar, Chambers, & Roberts, 2004). Although HIV prevention programs have reached a number of Aboriginal communities, few models tailored to the needs of Aboriginal youth exist (Majumdar, Chambers, & Roberts, 2004). Aboriginal youth tend to be excluded from community decision making and are instead passive recipients of decision makers at the centralized state levels (Kirmayer, Simpson & Cargo, 2003). Health promotion programs and practices are more effective when created from knowledge provided by Aboriginal youth themselves (Banister & Begoray, 2006; Moffitt & Vollman, 2004). It has been suggested that to effectively change behaviours of high-risk youth, program designs should include messages delivered by those who have similar life experiences (Villarruel, Sweet-Jemmott, Howard, Taylor, & Bush, 1998). Group discussion and increasing social connection is essential to achieving health goals with Aboriginal youth (McCormick, 1997a). McCormick (1997a) argues that "establishing a social connection and obtaining help/support from others" (p. 79) is a central

theme of First Nations healing. The traditional First Nations person is more likely to receive help from family, friends, and traditional healers than from mainstream mental health service providers (McCormick, 1997a).

Mentoring

Adolescence is a time in the life course when "possibilities for relationships present themselves and an adult can step in and make a significant difference" (Spencer, 2006, p. 313). Mentors have been shown to promote positive development through role modeling and emotional support (Grossman & Rhodes, 2002), facilitate improvements in adolescents' attitudes, self-perceptions and behaviours (Walker & Freedman, 1996), and reduce risky sexual behaviour among adolescent women (Taylor-Seehfer & Rew, 2000). "By observing adults and comparing their own performance to that of adults, adolescents can begin to adopt new behaviors" (Rhodes & Roffman, 2002, p. 232). In Aboriginal communities, role modeling within an individual or group context is an effective means for teaching others about traditional values and for the transmission of traditional knowledge (McCormick, 1994). Elders, healers, traditional teachers or community members can role model positive behaviours (Poonwassie & Charter, 2001).

Overview of the Study

Our community-based mentorship research project focused on understanding adolescent girls' sexual health concerns and best practices for addressing them (Banister & Begoray, 2006; Banister & Leadbeater, in press). We used an ethnographic research approach (Denzin, 1997; Tedlock, 2000) to obtain participants' perspective of their sexual health issues. Participants' "thick descriptions" (Geertz, 1973), which convey central meanings of experiences (Denzin, 2000), provided the empirical data used by this inductive research method (Fetterman, 1989).

Well established community-university partnerships from our previous research facilitated our access to participants (Banister & Schreiber, 2001). Forty adolescent participants, ages 15-16, were recruited through five sites including three local secondary schools, a youth health clinic; and a rural Aboriginal secondary school. Of the forty participants accessed for the study, ten were Aboriginal.

The study had two phases. During phase one, four consecutive focus groups were conducted with each of five groups of girls at their respective sites for obtaining ethnographic data on their sexual health concerns (Banister, Jakubec & Stein, 2004). Themes detected the complex interaction of power dynamics and socialization processes in the girls' relationships with men. Findings from the focus groups provided the foundation for the development of the mentoring program used in phase two. During phase two of the study, with the same girls who participated in the focus groups, we delivered the mentoring program weekly for 16 weeks, in 1.5 hour sessions. Each group had approximately eight girls, an adult woman mentor, and a research assistant. The four school sites incorporated the program into their regular school hours which facilitated a low attrition rate.

Mentoring Curriculum

The mentoring curriculum included strategies designed to facilitate egalitarian relationships in the groups, for example, circling where each person takes a turn to speak while others in the group listen in situations involving decision making or conflict (Banister & Begoray, 2004). Aspects of Wolfe, Wekerle and Scott's (1997) youth relationship project that used information, skill building, and social action to empower youth to end relationship violence were also included to increase learning about unhealthy power imbalances, and visits were made to local community resources to gain information (such as counseling services available for teens) and report back to the group (e.g., sexual assault centre). We incorporated a pedagogical approach known as "multiliteracies" (New London Group, 1996) to enhance participants' learning (see Banister & Begoray, 2004). Activities such as free writing and role playing and were used to encourage participants' use of a variety of sign systems (e.g., kinetics and visual design systems) for exploring multiple aspects of self and for expression (Begoray & Banister, 2005). Talking and writing are both literacy skills commonly used in educational settings to help learners to reflect on knowledge and understand it more deeply. One

girl said: "Yeah, it's helped like seeing other, I guess hearing other people's point of views and then kind of reflecting back on what I thought and then just like, thinking about what they do about it." Different communities call for a variety of literacy skills, not only reading and writing but also listening and speaking, viewing and visually representing. Moving between communities necessitates the ability for adolescents to deal with the challenges "perceived when negotiating personal, home/community, and school multiliteracies" (Hagood, 2000, p. 317).

Creating an Aboriginal Version of the Mentoring Curriculum

Because of the reported benefit of the mentoring program by the ten Aboriginal participants in the initial focus groups and program and because of the greater sexual health risks among Aboriginal women, we sought to create a second version of the curriculum that was tailored to the needs of Aboriginal youth and focused more specifically on sexual health education (see Banister & Begoray, 2006). A new group of adolescent Aboriginal women (N = 9, aged 15 to 17) was accessed from the same rural Aboriginal secondary school as before.

The curriculum offered Aboriginal youth the opportunity to share their stories and to obtain information about sexual health including HIV/AIDS information and prevention. Our use of a "teaching and sharing circle" for delivering the curriculum helped to reinforce the traditional belief that all knowledge is valued (Poonwassie & Charter, 2001, p. 67). In addition to the inclusion of Aboriginal girls' voices, we incorporated suggestions from the Aboriginal mentors and elder who helped facilitate the group. Two female Aboriginal school support staff members were chosen as mentors. In Aboriginal communities, elders are viewed and respected for knowing, living, and passing on traditional knowledge (Hunter, Logan, Goulet & Barton, 2006). The elder was not only a health care worker with the local band but knew all the girls and many of their health issues within their family and community context. She offered suggestions for group activities that were culturally appropriate; for example, participants created a wild woman necklace as a concrete symbol to remind them

of their authentic voice (Banister & Begoray, 2006). Native traditions such as storytelling (pertaining to the research topic) in addition to understanding the importance of body, mind, and spirit were woven into the program (Napoli, 2002). For example, the girls' short and long term goals for participation in the program were linked to the medicine wheel.

The elder's presence helped to remind the mentors and girls of their interconnectedness to the larger community and prepared the participants for their mentoring responsibilities within their Aboriginal community (Banister & Leadbeater, in press). The elder asserted:

> Some of them don't want to be in bad relationships and they'll find their way out of them and I think that some of them will, if I can keep telling them to keep sharing, that's how it's going to benefit the whole community.

The elder stressed the importance for older members of the community to transfer traditional knowledge about relationships to the girls: "It's an opportunity for me to be able to speak to the girls, to share more. They're just young kids and they need to keep hearing from the older people."

The mentoring program helped build community both within and outside of the group. For example, the group crossed divisions representing various family units in the Aboriginal community that were entrenched among groups of girls attending the school (Banister & Leadbeater, in press). As one girl said: "When all us girls, get together we connect … we share our problems … and things we like." The girls were practicing school and community participation norms. A mentor observed how the girls were reaching out to others beyond the group:

> From the beginning some of the girls would not talk, not even say good morning but now they are so open and they are socializing more. One girl was definitely that way, she would not talk. Now she is chatting up a storm for her teachers.

The elder and mentors' expertise helped foster participants' greater understanding of issues of sexual health (Richards, 2006). At

the same time, the girls were learning to utilize their own knowledge and resources related to sexual health decision making (Wenger, 1998). A participant said: "I learned how to say 'no.' To say 'no' when it's not right. Listen to your heart or guts." Bradley (2004) suggests that through encouraging a balance between learning from community resources and learning from one's own resources, individuals "may come to identify themselves as members of communities of practice" (p. 363).

Recommendations for Practice

Our research suggests that health practitioners' consider developing and implementing adolescent sexual health promotion programs that encourage dialogue among clients. Setting up groups that meet on a regular basis will allow building of relationships needed for effective transmission of information about sexual health. Health promotion programs that create communities of practice encourage productive conversations between experts and novices and help link youth to the larger community.

Health clinicians who are working with Aboriginal youth need to consider such youths' multiple contexts. For example, many Aboriginal youth live not only in family and tribal groups but also majority culture dominated schools and in multicultural communities. Being mindful of such youths' location can facilitate them to become successful border crossers, healthy adults, and successful life long learners. Health delivery contexts might therefore include spaces that are not only comfortable and youth friendly but have symbols, artifacts and personnel representing the Aboriginal community. This will help youth transition between traditional and Western contexts. For example, totems, bead work, hangings can be present in health clinics servicing Aboriginal youth.

Conclusion

In Aboriginal communities, involving members of the community and using local knowledge for delivering the message are crucial to effective sexual health education (Baldwin et al., 1999). Our sexual health program served to enhance Aboriginal girls' social connection and reinforced their sense of belonging and relational mutuality within the wider community. The community of practice environment helped the girls learn from others while at the same time learn to trust their resources from within (Bradley, 2004). In the words of one participant: "I learned that I have a choice in a relationship … and not to put up with any guy that abuses me." Our inclusive and egalitarian approach to sexual health education drew upon Aboriginal connectedness and offered the girls a source of resilience (Kirmayer, Simpson & Cargo, 2003).

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