Nurse Practitioners in First Nations Communities: Improving Access to Contraception - Decreasing Teenage Pregnancy

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Abstract

This paper addresses the question: "For isolated First Nations youth, would employing Nurse Practitioners on reserve to provide Primary Health Care reduce teen pregnancy rates compared to the present system of accessing Primary Health Care in neighboring larger centres?" Teenage pregnancy rates among First Nations are substantially higher than for Canadians at large. Additionally, culture and context are factors which play a significant role in this situation and must be acknowledged and incorporated into prevention efforts. The Conceptual Framework of Sexual Health for American Indian Youth (Kaufman, Desserich, Big Crow, Holy Rock, Keane & Mitchell, 2007) will be used as a reference for examining the literature and to guide the development of a tool for delivering Primary Health Care related to sexual health. Nurse Practitioners working in First Nations communities are poised to build long lasting bonds with communities while increasing access to contraception. In this paper it is argued that provision of contraception in a culturally safe framework will contribute to decreasing teen pregnancy rates while improving the overall health of First Nations communities.

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There is a paucity of literature regarding culturally safe practices for addressing Teen Pregnancy among First Nations (FN) communities, an issue interwoven with cultural and contextual implications. Ensuring that health care services are accessible and community based are two pivotal components of Primary Health Care (PHC) (Shoultz & Hatcher, 1997). PHC "…is the first level of contact of individuals, the family and community with the national health system bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process" (World Health Organization, 1978, p. 2; World Health Organization, 2008). Nurse Practitioners (NPs) are poised to provide PHC to underserviced populations such as FN communities and have been shown to provide care that is equivalent to that of their physician colleagues in many areas of patient care (Brown & Grimes, 1995; Horrocks, Anderson & Salisbury, 2002).

That the rates of adolescent pregnancy are higher for FN than for other Canadians is clear in the literature. Health Canada statistics from 2000 demonstrate that twenty percent of all FN births are to teen mothers compared to six percent for non-native Canadians (Health Canada, 2005). The impact of teen pregnancy is far reaching, affecting the health of entire communities. For many FN communities already stressed financially and emotionally, the added strain of teen pregnancy is overwhelming (Kenny, 2004). It is proposed in this document that better accessibility to contraception will lead to a decline in teenage pregnancy rates. The following discussion will explore the author's background, cultural context of this issue for FNs, and the chosen theoretical model, the Conceptual Framework of Sexual Health for American Indian Youth (Kaufman et al., 2007). Within the

literature review, findings as they relate to the chosen model as well as a framework for providing PHC related to sexual health within FN communities will be explored. The argument supporting NPs as providers of PHC to FNs will then be presented concluding with a model for culturally safe provision of contraception.

Background

The author is presently employed as a Community Health Nurse (CHN) for Carrier Sekani Family Services, a FN transferred health agency providing services to ten communities between the towns of Burns Lake and Vanderhoof in northern British Columbia. The role of CHN encompasses: Elder home visits, immunizations, prenatal care, dental varnishing to preschoolers, and other preventative services to communities. While the first few months in this position seemed very slow paced in terms of client visits, it is now clear that the community needed that time to get to know their new nurse, as the author also needed to get to know them. During regular visits to the band offices to inquire as to who should be seen that day, a response of "Go see the Elders," would resound. The author's thoughts would be, "But I just visited them all last week, they must be annoyed with all my visiting." As time went by, small changes began to occur. While visiting an Elder, she might discuss her family members and the health issues they were facing. The author now appreciates that Elders are gatekeepers of their family's health and that by earning their trust, one earns the trust of their families. Through this process, reproductive health began to emerge as a priority within all five of the FN communities in which the author was working.

The following narrative is about one of the first prenatal visits the author was asked to do. The client was a 16-year-old female living in a tiny one room dwelling an hour's drive from the nearest community. The young woman was eager to discuss the health of her unborn baby and pregnancy and readily disclosed that she had been using depo-medroxyprogesterone acetate injections for contraception but discontinued it as she did not like the effects of weight gain and amenorrhea. She stated that her doctor would not let her

use oral contraceptive pills as he felt she was too irresponsible (this incident was reported to the Medical Health Officer who has brought this issue to the attention of the College of Physicians and Surgeons). That she was pregnant was something she received with mixed emotions. This young woman has since struggled with the suicide of her partner and with substance use. Several years later, at the age of 18 she had been pregnant three times and has seen her children removed by the Ministry of Children and Family Development on numerous occasions due to her neglect and drug addiction. This is a tragic story and an extreme example, but it is shared to illustrate the point that, had contraception been readily available, this young woman may have had more choice regarding pregnancy planning.

There are many stories of young women torn by unplanned pregnancies, which on the one hand were celebrated by their families and themselves, yet their life circumstances made coping with such an event almost insurmountable. As will be discussed with regards to context, once established, pregnancy was to be celebrated; however, most of the women in the context of this author's practice had attempted to use a form of contraception prior to becoming pregnant and then discontinued it for one reason or another. In discussion with these women, barriers to accessing services such as transportation frequently arose as themes related to lack of consistent contraception usage.

Context

There is no doubt that the rates of adolescent pregnancy are higher for FN than for other Canadians. The birth rate as a whole for FN is twice that of non-native Canadian rate.

The way in which teen pregnancy is viewed is very different within FN culture compared to that of non-native Canadians. At the Aboriginal Roundtable on Sexual and Reproductive Health conducted by the Aboriginal Nurses Association of Canada, Indigenous participants verbalized an awareness of the fact that Canadians at large disapprove of adolescent parenthood; however, they were unwilling to further this negative view towards their own people who become pregnant while adolescents (Public Health Agency of Canada, 2000). Participants indicated that traditionally in FN societies, parents were commonly young at the birth of their first child. At present, it is the erosion of traditional support structures and values that causes health and social problems for teenage parents and their families as opposed to teen pregnancy itself (Public Health Agency of Canada, 2000). This concept is also illustrated in the following quotation from a qualitative summary of interviews with FN teenaged mothers, "What's left of the old way is a deep belief that a woman's purpose is to have children, and what is missing is the support that mothers need, especially when they are teenagers" (Olsen, 2005, p. 38).

This breakdown of cultural values and support systems is commonly attributed to colonization and the residential school system. The colonization of North American FN at the hands of European settlers, culminating with the residential school era during the nineteenth and twentieth centuries, has been compared to the Jewish holocaust. Survivors of colonization remain deeply wounded and these wounds continue to impact their descendents. Unresolved grief stemming from loss of lives, land and culture continues to

impact present generations in what one source has termed "the survivor's child complex" (Yellowhorse, Braveheart & DeBruyn, 1998, p. 60). The emotional impact of the survivor's child complex manifests in anger, guilt, sadness, and helplessness. Stemming from this ongoing trauma and pain are the current social issues experienced by many FN today (Yellowhorse et al., 1998). One such social issue is adolescent pregnancy with its far reaching effects. Compared to non-native Canadians, more Aboriginal women rear children alone and thus are less able to be employed, resulting in higher rates of poverty and ill health and lower rates of education. Higher birth rates also increase child-related expenses, furthering poverty (Kenny, 2004).

While many FN adolescents are high school students with goals and dreams for the future who do not plan on becoming teen parents, when substance use becomes a factor, usual sexual health precautions are often neglected. Substance use has been found to be the key variable in an American study on Native youth, resulting in more sexual partners and condom misuse with increased risk of sexually transmitted disease and pregnancy. The rates of substance use with intercourse are higher among this group than the national average (Mirsigia, Nieri & Stiffman, 2006). Prevention efforts must emphasize substance use as a risk factor for unprotected sex and its repercussions (Mirsigia, Nieri & Stiffman, 2006).

Another cultural component of teen pregnancy is the way in which abortion is viewed by some FN people. Although fifty-four percent of all teenage pregnancies in British Columbia now end in abortion, this is not the case for FN. While the statistic specific to FN is not known, there is generally an ingrained cultural understanding among many FN people that life begins at conception. A part of this is the belief that a life does not end when it is taken in this way. When a child is aborted, its spirit is believed to linger with

the mother and her family. Because of the abortion, this spirit is disturbed and afraid and might even seek harm on the family. Thus, there is a deep fear that once the life of a fetus is terminated, it will haunt the mother for the rest of her life (Olsen, 2005).

A major challenge for the delivery of health care services to FN communities is isolation, including long distances to hospitals and health clinics in larger neighboring communities (Gregory, 1992; O'Brien, Anslow, Begau, Pereira & Sullivan, 2006). In the most isolated of FN communities such as those in the far north, nurses function in expanded roles similar to NPs, as necessitated by access issues (Gregory, 1992). The major principles of PHC are accessibility, integration, accountability and sustainability as well as equitable distribution of health care resources, appropriate technology, a focus on health promotion and disease prevention, community participation and a multisectoral approach (Shoultz & Hatcher, 1997). Clearly, working within a PHC framework involves developing creative solutions to address the health needs of isolated communities.

Building on the context and background which have now been explored, the following question will guide the rest of this discussion: "For isolated FN youth, would employing NPs on reserve to provide PHC reduce teen pregnancy rates compared to the present system of accessing PHC in neighboring larger centres?" After a look at the theoretical framework and literature review process, findings will be described followed by a discussion and summary.

Theoretical Framework

A framework for addressing FN women's health is the Indigenist Stress-Coping Model (Walters & Simoni, 2002; Kaufman, et al., 2007). This model, as outlined below in Figure 1, presents stressors common in the lives of FN women including historical trauma, discrimination, and physical or sexual abuse. Mechanisms for coping with these include cultural buffers such as identity attitudes (personal feelings towards one's culture), enculturation, spirituality, and traditional health practices. Health outcomes are affected adversely when coping mechanisms are overwhelmed by stressors as manifested by HIV risk, morbidity, alcohol and drug use, and poor mental health (Kirmayer, Simpson & Cargo, 2003; Libby, Orton, Beals, Buchwald & Mason, 2008, Walters & Simoni, 2002). For FN, the health of communities stems from the health of its women, whose roles include… "life givers, teachers, socializers of children, healers, doctors, seers and warriors" (Walters & Simoni, 2002, p. 520).

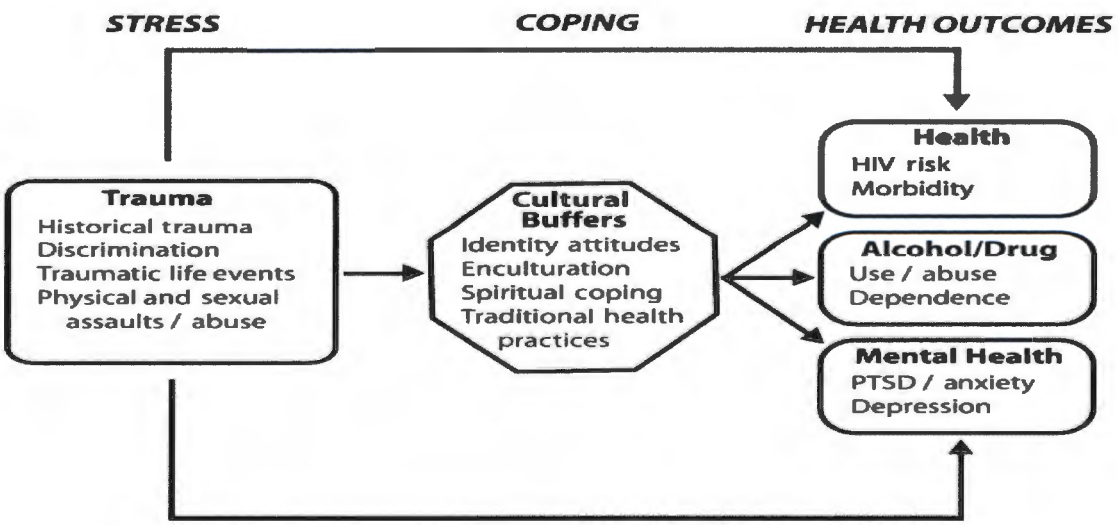

Figure 1. The Indigenist Stress-Coping Model (Walters & Simoni, 2002, p. 521)

Kaufman et al. adapted this model, forming a conceptual framework of sexual health for American Indian youth (2007) as illustrated below in Figure 2. For this age group,

stressors include anxiety and role transitions from childhood to adulthood with increasing maturity and responsibility. The stressors mentioned above relating to FN women in general also impact youth both directly and indirectly. These include discrimination, historical trauma, and traumatic life events. Cultural buffers drawn upon by FN youth may include identity attitudes, enculturation (the aspects of their lives which provide strength such as learning and practicing in traditional activities), and spiritual coping. In addition to stressors and cultural buffers, Kaufman et al. added a third variable to the model, that of risk context, which may include peer pressure, condom use, contraceptive use, alcohol and drug use and assault and violence. Risk context interplays with stressors and cultural buffers and results in sexual decision making with results such as early sexual activity, STDs, and teen pregnancy (Kaufman et al., 2007).

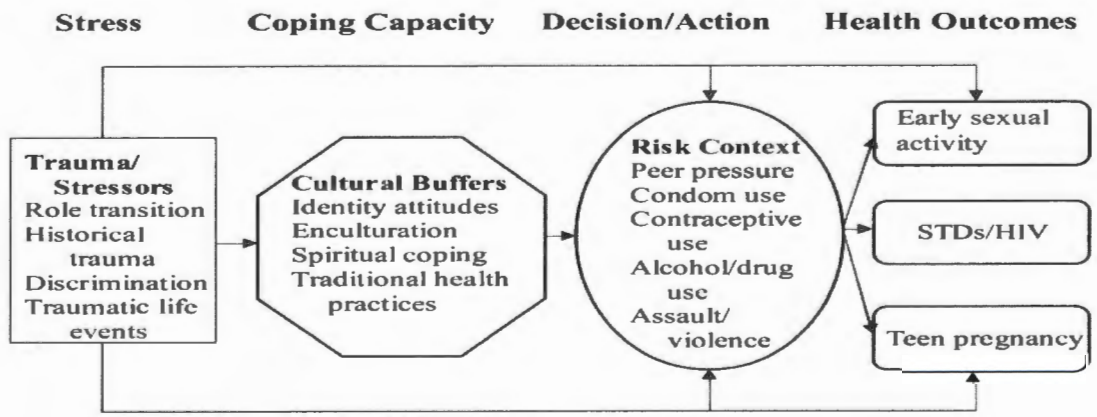

Figure 2. Conceptual Framework of Sexual Health for American Indian Youth (Kaufman, et al., 2007, p. 2154).

Program planning must acknowledge that socioenvironmental history and context play a significant role in the marginal health of FN compared to other Canadians. Ignoring these realities will only further paternalistic medical practices and continue to widen the gap between the health of FN and non natives (Walters & Simoni, 2002). Cultural buffers may

be drawn upon by American Indian youth to assist them in healthy sexual decision making. The framework suggests that program planners need to understand risk context, its relationship to cultural buffers, and health outcomes. By identifying factors in risk context and the influence these have on the outcome of unprotected sex, target areas for preventative efforts can be identified. Contraceptive use falls within the risk context section (Kaufman, et al., 2007) of the model and is the focus of the following literature review.

The conceptual framework of sexual health for American Indian youth (Kaufman et al., 2007) will be used in the literature review to categorize studies consistent or inconsistent with this view. It will also be used in the discussion as a framework suggested for developing a health promotion tool for improving access to contraception for FN adolescents.

Approach

In assembling this paper, a thorough review of the literature was conducted. No studies could be found using CINAHL or OVID Medline that answered all four aspects of the research question: "For isolated FN youth, would employing NPs on reserve to provide PHC reduce teen pregnancy rates compared to the present system of accessing PHC in neighboring larger centres?" Thus, the question was broken down and several searches were conducted as follows. CINAHL was searched using the CINAHL headings "Native Americans" and "Pregnancy in Adolescents" as the primary search. The secondary search used the CINAHL headings "Nurse Practitioners" and "Native Americans" and the third search used the headings "Contraception" and "Native Americans".

OVID Medline was then searched using the OVID headings "Indians, North American" and "Pregnancy in Adolescents" as the primary search. The secondary search used the OVID headings "Nurse Practitioners" and "Indians, North American" and the third search used OVID headings "Indians, North American" and "Contraception."

In addition to database searches, resources were accessed in the context of the author's graduate studies coursework as they arose. Lastly, additional sources were obtained after searching for cited references listed in several of the primary sources.

Findings

There is a limited volume of literature on teen pregnancy among FN and strategies to address this issue. Locating current Canadian sources was especially difficult. Also scarce is literature on culturally appropriate programming and what this should look like in practice. It is clear that services must acknowledge the social determinants of health while validating and building upon community strengths and successes of FN people in all areas of health program planning. A review of the literature is presented moving through two major sections: teen pregnancy among FN and program planning in the context of the research question.

Teen Pregnancy among First Nations

The primary search of OVID and CINAHL focused on the population portion of the research question- teen pregnancy among FN. In the studies obtained through this search, several themes arose. These include epidemiological data specific to teen pregnancy, FN beliefs related to teen pregnancy, research findings consistent with the conceptual framework of sexual health for American Indian youth, and research findings inconsistent with the conceptual framework of sexual health for American Indian Youth.

Epidemiology

Epidemiological data on teen pregnancy was the focus of several sources though these were not all specific to Canadian FN. United States statistics demonstrated that after a fourteen- year downward trend in teen pregnancy rates at a national level, rates actually increased by three percent in 2005. Reasons for this were attributed to complacency and a decrease in the use of contraception by adolescents. A general negativity on the part of Americans towards contraception was also discussed compared to a European attitude of

contraception acceptance which would appear to be associated with a much lower rate of teen pregnancy (Contraceptive Technology Update, 2008). Canadian data, while stated differently, indicate that despite a downward trend in teen pregnancy rates, 19,724 women aged fifteen to nineteen gave birth while 21,233 had an abortion. Infants born to teen parents are noted to have higher rates of low birth weights and associated health issues while teen mothers also have higher rates of health issues. Canadian teenage pregnancy rates were noted to be half those of the United States (Dryburg, 2000).

In both Canada and the US, children of teenage parents not only have lower birth weights, higher mortality rates, increased hospitalizations, greater risk for abuse, and lower levels of cognitive development but also are at higher risk for becoming teen parents themselves . Teenaged mothers have higher rates of social isolation, mental health issues, suicide, unemployment, and lower educational attainment(Horn, 1983; Langille, 2007). Adolescents who become pregnant tend to come from disadvantaged backgrounds. For society as a whole, the toll of teenage pregnancy extends to a strain on public assistance and welfare (Horn, 1983; Langille, 2007).

First Nations Beliefs related to Teen Pregnancy

As discussed in the conceptual framework of sexual health for American Indian youth, cultural beliefs related to teenage pregnancy are a critical indicator of behavior related to sexual risk taking and contraception usage (Kaufman et al., 2007). There is conflicting information in the literature as to what these beliefs actually consist of. Several authors commented on the diversity of FN communities and noted that not all findings may be generalized to other communities; recommending that programming efforts consider the cultural context of the specific community they intend to work among (Chewning, Douglas,

Kokotailo, LaCourt, St. Clair & Wilson, 2001; Garwick et al., 2008). This may explain the variety of cultural beliefs identified. Another explanation may be that the age of the available sources might reflect a changing attitude among some communities towards this issue.

A qualitative study carried out by Horn (1983) used interviews with Native Americans, African American and Caucasian teenage women to try to understand cultural variations in three main areas. These included prevention of pregnancy, significance of becoming a mother at an early age, and the kinds of support systems available within their social networks. First Nations adolescents interviewed believed contraception should not be used until after the birth of the 1st baby and that early pregnancy validated their roles as women and mothers. They also felt that should early pregnancy occur, support within their families and communities would be available (Horn, 1983). While this study is dated, it contains helpful information related to cultural context.

Edwards (1992) found that FN adolescents generally fear getting pregnant, though contraception usage rates are very low. The researchers used comprehensive surveys to determine the health status of Native American youths. The sample included 13,454 youth in grades seven through twelve who were surveyed with 162 questions specific to sexual behavior and orientation as well as multiple other health topics of interest to adolescents. "The Indian Adolescent Health Survey" was an anonymous self-administrated questionnaire. Findings noted that forty percent of sexually active males and fifty percent of sexually active females used contraceptives consistently and these rates were even lower among younger adolescents in grades seven to nine. Reasons for not using contraception provided by FN youth were most commonly that either the adolescent had not thought

about it or intercourse was unexpected. Less than ten percent selected the following reasons: they were embarrassed to seek contraception, their partner was unwilling to use it, they were concerned about side effects, or because they desired a pregnancy (Edwards, 1992).

Bissell's (2000) literature review examined socio-economic consequences of teenage pregnancy and the birth intentions of teenaged mothers. Bissell found that socioeconomic disadvantage was not only an effect of teenage pregnancy but also a cause. Additionally, cultural norms and individual needs of teenage women impact their decision to become mothers. Bissell's emphasis is that there are variations in cultural views among FN towards teen pregnancy. Thus, it is imperative for service providers to not make assumptions based on preconceived notions of what FN cultural beliefs are as this can lead to stereotyping and the perpetuating of inequities experienced by teenaged mothers and their children. Efforts at programming should aim to reduce socioeconomic variables rather than simply address teen pregnancy prevention (Bissell, 2000).

Research Findings Consistent with the Framework of Sexual Health for American Indian Youth

The majority of the research studies reviewed validated the Contextual Framework of Sexual Health for American Indian Youth (CFSHAIY); historical stressors and risk context were negatively associated with poor health outcomes such as teen pregnancy (Kaufman, et al., 2007). Of the seven applicable studies located in the search process, five were consistent with this model while two were not, these will now be described in more detail.

Consistent with the CFSHAIY is Hellerstedt, Peterson-Hickey, Rhodes and Garwick's (2006) study which used secondary data from a 2003 quantitative survey of 4,135 FN youth aged thirteen to fifteen. Conducted in the United States, this analysis looked at contextual factors and their influence on ever having had intercourse. Findings included that the strongest influence of ever having had intercourse among this group were risk behaviors such as substance use, violence exposure, and violence perpetuation (Hellerstedt et al., 2006). What these authors refer to as risk behaviors correspond with the CFSHAIY as in this framework, the impact of trauma and stressors are buffered by cultural engagement which affects youths' decisions and actions. These three areas interplay resulting in either positive or negative health outcomes (Kaufman, et al., 2007). Thus, while culture is not specifically discussed by Hellerstedt et al. (2006) the notion that risk taking behaviors correspond to early sexual debut is synchronous with the CFSHAIY (Kaufman et al., 2007).

Roberts, Phinney, Masse, Chen, Roberts, and Romero (1999) conducted a study in which 5,423 adolescents in grades six through eight from diverse ethnocultural groups completed the Multigroup Ethnic Identity Measure (MEIM). The MEIM is a quantitative tool developed by the researchers to define the level of cultural involvement of their subjects. These researchers noted ethnic identity to be a link to well-being (coping, self-esteem and optimism) while negative ethnic identity was found to be linked to depression and loneliness among the sample of European American, African American and Mexican American adolescents studied (Roberts et al., 1999). These findings are consistent with the CFSHAIY in which culture is seen as a buffer, interplaying with life stressors and risk context towards healthy sexual decision making while a lack of cultural buffers and risk context corresponds to early sexual risk taking, STDs and teen pregnancy (Kaufman et al., 2007).

Chewning, Douglas, Kokotailo, LaCourt, St. Clair and Wilson (2001) employed a different approach acknowledging that"… [FN] communities wish to learn as much as possible from their youth and families who are doing well, rather than focus simply on problems and risk behavior" (Chewning et al., 2001, p. 274). Emphasizing protective factors associated with healthy sexual decision making, these authors used quantitative written surveys while measuring four variables: delay of sexual debut, no intercourse in the past three months, birth control use in the past three months, and condom use in the past three months. The sample consisted of 484 FN youth in grades six through twelve. Protective factors towards higher rates of these variables included healthy behavior of peers, parental awareness and involvement with adolescent's activities and friends, having a higher value placed on academic achievement, higher academic performance, and higher

self-efficacy towards healthy sexuality. Recommendations were that prevention efforts build upon FN culture and uniqueness while working to strengthen these protective factors (Chewning et al., 2001). These are consistent with the suggestions of Kaufman et al. with regards to the role of the CFSHAIY in health program planning efforts in which planners identify risk context and health outcomes while validating historical trauma and seeking to strengthen cultural buffers (2007).

In a fourth study, previously mentioned under the section on First Nations Beliefs Specific to Teenage Pregnancy, researchers noted that emotional stress and a history of physical and sexual abuse were linked to early sexual debut. Religious identification was found to correlate with lower rates of sexual activity (Edwards, 1992). This study emphasizes the link between trauma and sexual risk taking behaviors described in the Kaufman, et al. (2007) CFSHAIY, but does not explore protective cultural factors or resulting health outcomes of early sexual debut (Edwards, 1992; Kaufman, et al., 2007).

Kenney, Reinholtz, and Angelini (1997) used a twenty page quantitative questionnaire to elicit information about women's sexual and pregnancy history, high-risk behaviors, and sexual abuse. The study sample included 1, 900 women ages eighteen to twenty-two. A significant link between the stress of a history of sexual abuse and the outcome of pregnancy was noted; female teens that had been sexually abused were twice as likely to become pregnant compared to teens that had not been sexually abused. Among ethnic minorities, both the rates of teen pregnancy and having a history of sexual coercion prior to becoming pregnant were higher. In comparison, Caucasian pregnant teens had higher rates of a prior history of rape (Kenney et al., 1997). Findings consistent with the CFSHAYI are that trauma; specifically sexual abuse, is linked to poor decision-making and

risk exposure such as unprotected sex. However, coping mechanisms such as cultural and spiritual buffers were not explored in this study (Kenney, et al., 1997; Kaufman et al., 2007).

Research Findings Inconsistent with the Conceptual Framework of Sexual Health for American Indian Youth

The concepts of the CFSHAIY were challenged in two of the studies reviewed. The first of these, by Jumping-Eagle, Sheeder, Kelly and Stevens- Simons (2008) sampled 351 sexually experienced female adolescents. The researchers invited young women from racially-mixed backgrounds who were inconsistent with contraception use to participate in a quantitative survey. Variables included educational and vocational goals and the perception of pregnancy as an impediment to achieving these. The study examined whether risk and protective factors actually interplay resulting in sexual health outcomes. Conclusions were that personal and cultural attitudes towards pregnancy on the part of adolescents were the biggest predictor of teen pregnancy outcomes. The authors proposed that prevention efforts strive to shift adolescents' perspective to showing that teen pregnancy would have deleterious outcomes on life goals (Jumping-Eagle, et al., 2008). Thus, these authors did not explore the relationship between trauma, coping or health outcomes related to sexual risk taking but focused instead on belief systems regarding teen pregnancy as a predictor of risk taking behavior with regards to contraception (Jumping-Eagle, et al., 2008; Kaufman, et al., 2007).

The second study by Mitchell, Kaufman, Beals and the Pathways of Choice and Healthy Ways Project team (2005) sampled 518 American Indian adolescents using a latent growth curve model while drawing on social cognitive theory. Variables examined were association between resistive efficacy or "…expectancies that one can successfully resist external pressures to participate in transgressive or risky behaviors" (Mitchell et al., 2005, p. 162) and multiple sexual partners. This study had mixed results, but did establish that

higher levels of resistive efficacy corresponded with the lower number of sexual partners in the past year. As a result of this study, the authors implemented an initiative for HIV prevention focused on building efficacy among FN high school students (Mitchell, et al., 2005). The findings of this study emphasized building upon an individual's ability to resist pressures as a buffer for sexual risk taking behaviors, as opposed to strengthening culture as emphasized in the Indigenist Stress-Coping Model. While not entirely inconsistent with the model, the emphasis is more simplistic, with a focus on building individual capacity rather than resolving historical trauma through strengthening cultural identity (Mitchell, et al., 2005; Kaufman et al., 2007).

While it was difficult to find sources addressing multiple aspects of the research question, many sources were relevant, though not all were current or Canadian. Key findings from this review include that teen pregnancy has community-wide effects, thus stakeholders at all levels of the community should be involved in program planning. Program planners should seek to gain cultural awareness of the particular community in which the intervention is being planned and adapt it to suit these. Preventing teen pregnancy must include building awareness and discussions as to the realities of pregnancy and childrearing. The importance of acknowledging and addressing socioeconomic circumstances and the role of substance use as variables in sexual risk taking cannot be overstated. Building on existing individual and community strengths; whether ethnic identity, culture, individuality, or religion, is an important step in building resistive efficacy towards healthy sexual decision making. At the same time, acknowledging pain, suffering and stress and their link to higher rates of teen pregnancy will help guide preventative efforts for the most vulnerable. Program planners should not only seek to become aware of

the adolescents' perspectives towards teen pregnancy, but also seek to shift views by showing the effect such an event would have on life goals.

Program Planning

This second major portion of the literature review outlines themes with regards to effective practices for professionals working with FN drawing on the intervention and outcome portions of the research question. Culturally appropriate teen pregnancy prevention programs are outlined, followed by a discussion of the NP role as a means of improving access to PHC services in isolated FN communities.

Culturally Appropriate Teen Pregnancy Prevention Programs

Begoray and Banister (2006b) present that FN adolescent sexual health promotion should incorporate regular meetings of adolescents for dialogue. These should occur in spaces that acknowledge the dichotomy of FN youth today- their culture and the majority culture in which they go to school. Thus the context for health care delivery might have aspects of both- such as FN art, providing refreshments, while playing music that the youth would enjoy. Community members such as elder mentors and leaders should be valued and involved in dialogue as well (Banister & Begoray, 2006b).

A culturally appropriate sexual health education project which used principles of literacy education among FN teenage girls was reviewed. This project employed a female FN mentor, using small-group circling, closing, codes of conduct, goal-setting and guest speakers. The project was presented as a means of engaging FN youth to empower themselves towards healthy sexual decision making. It grounded itself in the youths' contexts and built upon the lived experiences of the girls (Banister & Begoray, 2006a).

Talking circles are presented as a culturally appropriate tool for contextual exploration and health education while working with FN women specific to cancer (Becker,

Affonso & Blue Horse Beard 2006). This qualitative study used a purposive sample of twenty-eight women aged thirty-five to seventy-five who were recruited into talking circles. For best practices in providing screening services to this population, the talking circle format was effective in discovering the cultural knowledge that FN women have about cancer. Data collected include that scheduling of appointments negatively affects attendance, invasive procedures such as a pap smear are viewed as a traumatic event, and that the voices of family members who had experienced these aspects of health care were largely where women obtained their knowledge about screening procedures and cancer (Becker, Affonso & Blue Horse Beard, 2006). While not directly related to the population of interest of this literature review, the talking circle format could be an appropriate tool for adolescent teen pregnancy prevention as previously discussed in the model presented by Begoray and Banister (2006a). As Becker et al note, cultural meaning is discovered in this method, and education may be built into the circling discussion (2006).

In a qualitative study, Garwick et al. (2008) sampled 148 FN youth never involved in a pregnancy using focus groups to gain an understanding of what these youth would like to see in terms of teen pregnancy recommendations. Findings included that programs should show the consequences of pregnancy and work to enhance programs both in schools and in FN communities. Youth identified that contraception needed to be more accessible and that teen pregnancy should be discussed with youth. They recommended involving the media to reach youth and having knowledgeable and trusted FN family and community leaders be involved in discussions (Garwick et al., 2008).

The National Institute for Health and Clinical Excellence (2007) outlines guideline recommendations as to how one to one interventions can help reduce sexually transmitted

infections and teen pregnancy particularly. Recommendations from this document include that when working with high risk youth under eighteen years of age (from disadvantaged backgrounds, living in foster care, and or having achieved low levels of education) PHC providers working both in health care settings and outreach areas should focus on providing one to one sexual health advice. This should include information on preventing sexually transmitted infections, unplanned pregnancies, contraceptive choices including emergency contraception, and other reproductive issues and concerns (National Institute for Health and Clinical Excellence, 2007).

Key themes arose in this section of the literature review for program planning. These include utilizing the talking circle format within youth friendly spaces, increasing access to contraception, and providing one to one sexual health advice.

The Nurse Practitioner Role

Several studies compared PHC provided by NPs compared to physicians. The first of these, by Brown and Grimes (1995), included thirty-eight NP and fifteen Nurse Midwife studies in its review. Findings included that patient satisfaction and resolution of pathological conditions were slightly greater for patients of NPs than patients of physicians while for other variables studied, results were equal (Brown & Grimes, 1995).

An older information synthesis by Feldman, Ventura and Crosby (1987) included literature searches and an information synthesis. Their review found that generally NPs provided equal service to that of physicians at a lower cost. Additionally NPs spend more time on patient education and improved patient access to primary health care services (Feldman, et al., 1987).

More recently, Horrocks, Anderson and Salisbury (2002) conducted a systematic review of eleven randomized control trials and twenty-three prospective observational studies. These authors noted that compared to patients of physicians, patients of NPs were more satisfied with their care, received longer consultations and more investigation, while all other aspects of their care identified were found to be equivalent to care provided by physicians (Horrocks, et al., 2002).

In summary, it can be argued from the literature that patients of NPs are generally satisfied with their care; NPs place a strong emphasis on patient education, and help improve access to PHC. Following this literature review, synthesis and application will be presented. The following discussion and summary will examine themes within the literature and present a tool for application of these using the conceptual framework for American Indian youth.

Discussion

The present context of health care services to FN communities across Canada began with the signing of Treaty Six in 1880 (Waldram, Herring & Young, 2006). This document initiated federal provision of health services to FN people with the clause of the provision of a Medicine Chest by the Indian Agent. While the meaning of this treaty has been fraught with controversy, the current federal system of health care delivery to on reserve FN in Canada stemming from this agreement includes provision of comprehensive nursing care, mental health and addictions services, home support services, and the Community Health Representative program, though these services may vary between communities (Waldram, et al., 2006).

With regards to reproductive health services that are accessible to adolescents, confidential counseling, pregnancy testing, referral services, and prenatal care are provided within this framework to on-reserve FN. These services are generally provided by Federally employed Community Health Nurses (Waldram et al., 2006). Additionally, adolescents receive some sexual health education within the public school system; however, should an individual be absent or no longer attending high school when these brief classroom sessions are offered, this critical information may not be obtained.

Primary Health Care Considerations

A lack of primary health care is a gap in service delivery to FN communities at present. As provincially employed physicians do not usually provide service to isolated reserve communities, adolescents must leave the familiarity of their often remote communities to seek out providers who are not well known to them for sexual health services such as contraceptive counseling and STD testing. If contraception is obtained, it may be discontinued due to an unpleasant side effect or lack of continuity of care. Difficulty accessing services is commonly verbalized as a barrier to obtaining alternate contraception for adolescents who do not wish to become pregnant(Olsen, 2005; Public Health Agency of Canada, 2000). Recommendations from the aforementioned Aboriginal roundtable discussion include that programming must: be holistic and culturally appropriate, include parents in educational initiatives in order to foster open communication between parents and their children, and ensure that contraception is accessible while providing education regarding its benefits and risks to all members of the community (Public Health Agency of Canada, 2000).

NPs who are consistent and known to the community can help to bridge the gap of access to primary health care (Browne & Tarlier, 2006). It is important to engage with community leaders and Elders on initiatives to ensure that information is culturally appropriate and that community input is obtained throughout the process of program development. Within this framework the NP integrates with all community members, holds discussions with Elders and leaders seeking their counsel and input, and seeks to involve

members of the community in meaningful ways in reaching adolescents in their present context.

Inequities between the health status of FN and mainstream Canadians have been discussed in a historical context related to colonization and its ongoing traumatic effects. The state of Canada's FN mental and physical health has been called "A Nation's disgrace" (Gregory, 1992, p. 183). Contributing to this situation is Western medicine and its biomedical focus on disease, treatment and prevention, which at times may be inconsistent with the culturally safe holistic care desired by FN communities (Banister & Begoray, 2006b). Isolation of many FN communities results in difficulty accessing health care services (O'Brien, et al., 2006). Thus, it is essential that prevention efforts focus on incorporating these principles into program planning.

The NP role has been evolving within mainstream healthcare for over thirty years in North America. In British Columbia, these are Registered Nurses whose expanded scope of practice is formed by the context in which they are certified to practice via a clinically focused master's degree (Browne & Tarlier, 2006). Historically, NP roles providing PHC evolved in areas where human social needs went unmet (O'Brien, et al., 2006). It is only recently that this role has been formally recognized in most Canadian provinces and territories exclusive of Prince Edward Island and the Yukon Territory (Canadian Institute for Health Information, 2006). The integration of NPs into Canadian healthcare is being done with goals of improving access to PHC while saving money, as wages are considerably lower than those of physicians (Browne & Tarlier, 2006).

The care that NPs provide is effective, of high quality, and economical (Browne & Tarlier, 2006). Canada's outpost nurses have traditionally provided PHC to FN

communities and are recognized as working in NP roles. These nurses work to provide PHC while addressing the social determinants adversely affecting the health of the communities in their care. In the modern context, masters prepared NPs continue to work from a perspective of wellness while addressing social inequalities and disparities in health (Browne & Tarlier, 2006). While now practicing in many conventional settings, NPs continue to work in underserved communities, meeting the challenge of providing PHC and case management services (O'Brien, et al., 2006).

NP practice is informed by a critical awareness of inequalities and the health care needs of Canada's most vulnerable citizens. This includes allocating time for advocacy against racializing or marginalizing health-care practices, political lobbying for social and economic change, and other political actions that will help to narrow the gaps in health care disparities (Browne & Tarlier, 2008). In so doing, the value system of the NP includes cultural respect, empowerment, self-determination and accountability (O'Brien, et al., 2006).

The NP role is noted to be appropriate to FN culture as it is comprehensive and constructed based on the needs of the population. NPs are poised to work in collaboration with existing community strengths and resources in a role that combines both PHC and case management. O'Brien et al (2006) note that as a result of the social stressors presently encountered in many FN communities, many FN are hesitant to trust health care workers. Some FN may not understand the health care goals of PHC as their personal health goals are more related to survival than long term health outcomes. Values that a NP must convey in their practice to such communities include "… human dignity, cultural respect, accountability, and advocacy" (O'Brien, et al., 2006, p. 54).

When specifically addressing teenage pregnancy, it is important for the NP to be knowledgeable as to the cultural beliefs of the community regarding this issue. For example, some FN adolescents believe that their feminine role is strongly defined by early pregnancy and childbirth. Thus, efforts to prevent teenage pregnancy must explore with the teen the pros and cons of teenage pregnancy and support decision making around this (Horn, 1983). While evidence generally is used to inform practice, when working with a community, it is always important to remember that research on FN in general will not necessarily be applicable to every FN group, as diversity exists between each community (Chewning et al., 2001).

An understanding of cultural meaning is imperative for nurses working with any ethno-cultural group. Nurses need to be aware of their patients as cultural beings, whose whole is greater than their various parts. Thus, consistent with the FN philosophy of medicine wheel in which the spiritual, physical, emotional and mental are part of the whole, NPs must view the physiologic, psychologic, cultural and spiritual dimensions of our patients as inseparable (Mendyka, 2000). That the service provider must be open to dialogue with patients that includes personal disclosure for the purpose of building trust is presented as key to providing health care to FN women. Participating in cultural activities and working to build empathy, trust, acceptance and understanding of value differences are all important components of building an awareness of cultural meaning (Napoli, 2002).

A Model for Service Delivery

The following is an exploration of a model within the conceptual framework of sexual health for American Indian Youth (Kaufman et al., 2007). Consistent with this framework, health promotion activities would seek to acknowledge socioenvironmental history and context. From there, health providers could plan programs aimed at decreasing stressors, while building on cultural buffers such as identity attitudes and enculturation (Kaufman et al., 2007). Working with a multidisciplinary integration framework, regular youth nights would be held in communities in contexts conducive to the engagement of adolescents. That is, these would take place in "youth friendly" spaces (Banister & Begoray, 2006a, p. 173) including elements of both cultures in the youths' experiences. Such a space would provide food and music in a drug and alcohol free environment while drawing on youth mentors as educators. Participants would bring their own music, while the team may provide pizza and other refreshments, in a setting with Native art or photos of the community's elders. As well as accessible one-on-one counseling, a multidisciplinary team approach could be utilized with the direction and involvement of community leaders and Elders. Appropriate community resources could include a youth worker, a Community Health Representative, a mental health counselor, an addictions worker, as well as a NP. Working in collaboration, these services would be available as a part of regular youth nights in communities. Guest speakers could include teen parents from the community, parents who have chosen to have children later in life, Elders and other community role models. These youth nights could be held monthly in each community.

Having the NP available at such times for confidential counseling sessions or group sessions could help to bridge the gap in PHC. FN youth today find themselves between

cultures – those of their extended families within communities and the white-dominated high schools where much of their time is spent. Effective program planning should try to provide spaces that draw on both of these contexts in order to build on the lived experiences of these young people (Banister & Begoray, 2006). First Nations youth have much to say with regards to how they would like to learn about reproductive health. Some of their suggestions include incorporating: presentations by teen parents in the community, simulated mechanical babies as a visual and hands-on tool, opportunities for teens to take care of real babies, and outreach programs to communities while providing access to contraceptives (Garwick, et al., 2008).

As has been argued in this paper, reaching youth within their communities is a key component to successful provision of contraception. Guideline recommendations for reducing both rates of STI's and teen pregnancy among young people of disadvantaged backgrounds include provision of one to one sexual health advice on pregnancy prevention, pregnancy testing, and long term and emergency contraception by a primary health care provider. Reinforcement of this information with regular structured counseling sessions has been found on a national level to increase rates of contraception adherence, particularly with regards to the depo-medroxyprogesterone acetate injection (National Institute for Clinical Excellence, 2007; Halpern, Grimes, Lopez & Gallo, 2006).

Summary

This author proposes that contraception that is readily available to communities via a trusted confidential provider would facilitate a decrease in the rates of teen and unplanned pregnancies. Certainly, it is idealistic to imagine NPs available to all FN communities, as presently there are so few NPs in British Columbia. Indeed, the BC Nurse Practitioner Association notes that they only recently reached one hundred members (British Columbia Nurse Practitioner Association, 2009).

Additionally, NPs are not currently within the federally-funded budget of programs to FN which were previously explored in this paper. Models are emerging within British Columbia presently in which partnerships are being developed between health authorities and FN health organizations. An example of this is in the community of Fraser Lake where the provincially employed NP regularly visits the neighboring reserves providing PHC through the existing health centres there as well as home visits as needed. This author would like to see a similar model adopted in the community of Burns Lake and has approached Carrier Sekani Family Services, the local First Nations health services provider, and the Northern Health Authority regarding a partnering plan for hiring an NP. If that is successful, planning with communities would be the next step. The author is of the opinion that community planning would go fairly smoothly as based on the findings from this project and in her experience, community based reproductive health programming has been well received.

As a non-native NP who is not part of the FN community, the author must maintain awareness that the concept of this project may not be what communities want at this time. Thus, openness while approaching community leaders and stakeholders towards the process

of program development and implementation must be maintained. Using a strength based model and ensuring that stakeholders have ownership of the model would likely help to prevent an outcome where the proposed framework is rejected.

Conclusion

Teen pregnancy among FN is an issue that impacts everyone: young women and men who become parents while still youths, the new lives now in their care, and the families and communities who are already strained by poverty and the intergenerational trauma of colonization (Kenny, 2004). While pregnancy is generally viewed positively for families who may believe that it should not be interfered with once conception has occurred, many FN are open to preventative actions for teen pregnancy, including readily accessible contraception (Public Health Agency of Canada, 2000).

Alongside the Elders and community leaders, a NP who is trusted by the community may readily provide such a service along with reproductive counseling. Implementing the presented tool while improving access to culturally appropriate PHC is a step in bridging the gap of health inequities between FN and Non-Native Canadians- part of lessening our nation's disgrace.

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