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# Health Promotion, Community Development, and Participation: An Approach to Native Health Education


## SUMMARY

Health-care parameters for Natives living in isolated northern areas of Canada show rates of life expectancy, morbidity, and infant mortality far worse than the Canadian average. Improving access to medical facilities has not affected these statistics. Socioeconomic factors such as inadequate housing and lack of sewage systems are likely contributors to poor health, as is an attitude of hopelessness and impotence on the part of Native people. Health-care providers have recognized the need for health promotion as well as treatment, but have often instituted programs that blame the victim. An approach to health education that embodies community development, participation, and the fostering of a positive self-image is discussed. The implication of this approach is that when Native Canadian groups can identify their own health problems, have access to the information needed for their solution, and develop the confidence and assertiveness to act, change may occur at a community, as well as an individual, level. (*Can Fam Physician* 1988; 34:1625–1627.)


**Key words:** health education, Native people, socioeconomic conditions


## RÉSUMÉ

Les paramètres servant à mesurer la santé des autochtones des régions nordiques et isolées du Canada révèlent des taux de longévité, de morbidité et de mortalité infantile beaucoup moins favorables que pour la population canadienne moyenne. Le fait d'améliorer l'accès aux facilités médicales n'a pas affecté ces statistiques. Les facteurs socio-économiques, tels les facilités de logement inadéquates et l'absence de facilités pour éliminer les eaux usées, contribuent vraisemblablement au piètre état de santé, tout comme une attitude de désespoir et d'impuissance de la part des autochtones. Les dispensateurs de soins ont reconnu la nécessité de promouvoir la santé et de s'en préoccuper, mais ont souvent mis sur pied des programmes qui rendent la victime responsable. L'auteur discute d'une approche à l'éducation sanitaire qui englobe le développement et la participaction communautaires de même qu'un image positive de soi. Par cette approche, c'est-à-dire en identifiant ses propres problèmes de santé, en ayant accès à l'information requise pour les solutionner et en développant la confiance et l'assurance pour agir, on pourra possiblement apporter un changement tant au niveau de la communauté qu'au niveau individuel.


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COMMUNICATIONS and transportation systems have brought big-city medicine to some of the most isolated areas of Canada. Telephones, airstrips, telemedicine (video connections to large centres), and the funding necessary to use these resources, have linked Northern medicine to the south. Yet the morbidity and mortality of people in more isolated areas, and particularly of Native people, continue to be far greater than the Canadian average. With improvements in existing social and environmental factors such as poor housing, contaminated water supply, and lack of bathing facilities, general health may also improve.[1] Possibly because these factors fall loosely into the category of public health, health education (another component of the public health 'catch-all') is sometimes thought to be one of the missing links in improving the overall health of the Northern Native community. Posters laud the benefits of boiling lake water for drinking, of regular bathing and nutritious eating, avoidance of alcohol, and so

forth. The implication is that one's state of health is determined by one's own behaviour, and that conversely, illness is the fault of the individual (an instance of "blaming the victim"). People are encouraged to take responsibility for themselves and their lives.

Two shortcomings are evident in this philosophy. First, an individual approach to social determinants of illness may help the individual to function within the limitations of these determinants, but does nothing to change those limitations. Secondly, telling people to be self-reliant ignores the hopelessness and helplessness of people who have, until recently, been treated as irresponsible and incapable of making decisions affecting their lives.

> The relationship between rural hopelessness and health is a complex one. Ill health adds to hopelessness, but its removal does not mean that there is hope . . . We should have to add such qualities as . . . human dignity, a capacity for improvement and change, organization and responsibility, and mastery over one's fate. The problem and the priority have to be the total rural helplessness complex and not just ill health. Health may have a low ranking among the starting points for change.[2]

If the preceding concepts are accepted, health education must involve more than the transferral of numerous facts from teacher to learner. Health educators should provide the resources necessary for people to implement social changes that will ultimately improve their health, and do so in a form that fosters positive self-images. The process may be long, slow, and without blueprints. The health educator is a facilitator, rather than a teacher, and learns as much from those with whom he/she works as vice versa. The starting point is with people, with their identification of health problems, and their involvement in discussions on how to solve these problems. People who are unaccustomed to this type of decision making, however, may lack the confidence even to state their opinions, and instead, defer to 'experts'. Though it is easy for these experts to lay out a plan for change, unless that plan comes from the community involved and, therefore, suits its people culturally, it will most likely fail. The conflict that arose over a proposed sewage system for a reservation in north-western Ontario illustrates this problem.[3]

The World Health Organization has defined health as:

> . . . a state of complete physical, mental, and social wellbeing, and not merely the absence of disease or infirmity.[4]

Implicit in this definition is the necessity for preventive medicine, education, and health promotion as part of a health-care delivery system. This does not negate the importance of acute care medicine or of access to treatment when one is sick. But the WHO definition goes beyond this point to recognize that social well-being is significant to the maintenance of health, and that some of the determinants of health are social or environmental. Curative medicine cannot alter these etologic factors:

> Despite differences of culture, language and race, the rural poor of all continents share a common bond forged of poverty, exploitation, disease, malnutrition, and land hunger. The old answer was a simple one: "We will eradicate disease by curing the sick." . . . No sooner was the patient cured than he returned to a slough of poverty that once again felled him with months, often days, of his treatment.[2]

What activities are likely to improve the overall health status of a population? In a study of Native health care in north-western Ontario, Young compared the infant mortality, death rate, and other statistics for communities serviced primarily by nurse practitioners and those served by lay community-health representatives (CHRs). He found statistics for both to be similar and poorer than the Canadian average.[5] This same health status has persisted unaltered, over the last 13 years, despite the presence of more and more highly trained personnel throughout the geographic area studied.[1]

It is tempting to grasp at health education and promotion as a potential solution, and attempts have been made to determine whether more health education has a positive effect on behaviour and lifestyle. The findings are somewhat contradictory. There are numerous affirmative reports; questionnaires examining behaviour before and after teaching have suggested positive outcomes.[6] On the other hand, one senses that despite massive education about the hazards of smoking, for example, the effect of the many campaigns in actually altering behaviour has been minimal. Perhaps the form of education offered, that is, the manner in which instruction is delivered, and the import of this manner as well as the relevance of the content, are of greatest significance in the success of any program.

Wellness is both a mental and physical state. It implies a positive self-image, and a sense of self-worth. Without control over the decision making that affects one's life, one has a sense of inferiority, incapacity, and hopelessness.

"Alcoholism thrives in the situation of extreme stress, where good self images are not encouraged, and where there is a lack of economic opportunity," said a Native alcohol- and drug-abuse worker quoted in an article on the problems of Native health care.[7] There is a trend in federally sponsored Native health care to encourage, in theory at least, responsibility for self, and to minimalize paternalistic behaviour. But an individual with low self-esteem—one who has been told repeatedly, either overtly or covertly, that his/her ideas and ways are inferior—cannot suddenly perceive her/himself as capable of responsible decision making.

The health-care profession has its share of idealistic and dedicated workers. Northern and isolated areas of Canada seem particularly to attract MDs and RNs. Why then, after a year of two, do so many leave the North, feeling bitter and disillusioned, and saying, "Nothing has changed. Nothing will change"? They have made do with buildings, equipment, and communication systems that are sometimes inadequate. They have attempted to bring the southern health-care model of 'more is

better'—more doctors, more specialists, more tests, more equipment—to the North, and within the financial and geographic limitations involved, they have succeeded. They have done their required public health teaching: talking about boiling water to purify it, eating less sugar, the evils of cigarettes and alcohol. But they see no definable change in people's behaviour or health. Often no one seems to hear all the talk, even though people appear to listen politely.

Accepting the WHO concepts that self-determination and self-worth are integral to health may help to redirect the efforts of these "burnt out" Northern health care workers. Since medical service generally is provided for those in need, it is thought that the patient should accept it gratefully, even if the service is not on his terms, but on those of the provider. But medicine should be practised for the benefit of the patient, in a manner understood by, and acceptable to him, and with the patient participating in the decision making on what is to happen to his health and his life. "Care" should be so dedicated, and so delivered that the patient can help decide his own medical destiny. Most medical delivery systems do facilitate such patient participation.

The challenge to health-care personnel then, is to work with people, by getting to know them, and to be known to them. When these two groups work together, the acute and long-term health problems of an area can be identified, and culturally relevant and technologically appropriate solutions can be sought, blending the medical expertise of the professional and the commonsense expertise of the population involved. The process cannot be itemized or outlined in advance, as it is a process: one between teacher-student, and student-teacher. Implicit is the health-care promoter's willingness to listen and to learn, and to spend a good deal of time in these activities, rather than arriving with a pre-packaged program. Instead of people remaining passive because they are treated as devoid of knowledge, as empty boxes are to be filled by the knowledgeable expert (the "banking system" of education), they become active and essential participants in a dynamic process. The banking system, either intentionally or unintentionally, embodies the "blaming the victim" approach: people are taught, for instance, that cleanliness contributes to health; therefore, by implication, illness is caused by dirtiness and is one's own fault. If, on the other hand, the problem of illness is introduced by a discussion of why skin infections are so prevalent, the answer from people may be, "because of the difficulty of bathing when one has no running water".

The cause of the problem is now identified in social, rather than individual, terms. The difference may seem subtle, but it is one of more than minimal significance in breaking the self-image of irresponsibility and worthlessness that the banking system has so repeatedly reinforced. As people accept their own self-worth, they may develop both a confidence in their ability to change the social determinants of illness and a hopefulness about their future, that will increase their desire to maintain good health. Again, the link is obvious between people's social and environmental circumstances, self-image, and health. A successful health-promotion program must recognize this link, and confront all aspects of any given health problem. ■

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# Answer to Dermacase (page 1550)

### 1. Prurigo nodularis

Prurigo nodularis is a skin disorder characterized by discreet hyperkeratotic nodules that result from repetitive scratching.[1] Pruritus is the predominant symptom. Often the initial itching may be spontaneous, or it may begin in areas of dryness or irritation from clothing or insect bites. When the skin thickens from scratching, the pruritus intensifies. In longstanding lesions, there may be both hyperpigmentation or hypopigmentation. Histologically the lesions will show both hyperkeratosis and acanthosis of the skin. In the past this skin change was often referred to as "localized neurodermatitis".

The application of low- or medium-potency cortico-steroids usually does very little. The use of high-potency steroid with saran occlusion for several weeks to months is necessary. If after a reasonable trial with topical corticosteroid, there is very little improvement, the use of intralesional triamcinolone (10mg/cc) injection[2] will quickly reduce the pruritus and eliminate the nodules. ■

## References


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