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Re-Evaluating Current Public Health Policy: Alternative Public Health Nursing Approaches to Sexually Transmitted Infection Testing for Teens and Males who Have Sex with Males

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ABSTRACT ***Objective:*** Due to a recent increase in the rates of reportable sexually transmitted infections (STI) across Canada, and the movement of public health nursing initiatives to a health promotion/illness prevention model, this paper proposes alternative strategies to current public health initiatives to encourage individuals who are labelled as at-risk by public health discourses, such as teens and males who have sex with males (MSM), to undertake preventative screening. ***Theoretical Design:*** To undertake this task, we approached Health Canada's (2002) determinants of health utilizing Lupton's (1995) post-structuralist work on public health to suggest that for some members of these groups, health is not an imperative. ***Conclusions:*** As such, we propose that increasing anonymous testing and its advertisement would provide one means of providing population-sensitive care and could thus increase the screening rates of individuals within groups who reject the public health "healthy" disquisition.

Key words: determinants of health, health policy, public health nursing, sexually transmitted infections.

Over the last 5 years, there has been an increase in reportable sexually transmitted infections (STIs) across Canada. As public health nursing ideologies have been changing over the last two decades to reflect a health promotion/illness prevention approach (MacDonald, 2002; O'Neill, Pederson, & Rootman, 2000), this resurgence has created a public health concern that has resulted in strategies to reduce STI rates and prevent health problems, such as pelvic inflammatory disease, chronic pelvic pain, infertility, and death, caused by these infections (Health Canada, 1998). This article aims at examining the recent increase in STIs in Canada by using Health Canada's (2002) determinants of health through the lens of Lupton's (1995) work. By analyzing Health Canada's (2002) determinants of health as they apply to such high-risk groups as teens and males having sex with males (MSMs), suggestions can be provided for nurses working at the policy level that potentially affects this group's health status.

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Significance of Issue

According to recent STI reports (Health Canada, 2004) from which all of the following STI rates are cited, the incidence of chlamydia (as calculated on a 100,000 population size) has increased over the last 3 years. In 2002, the national rate was 178.9 (178.9/100,000), which increased to 188.2 in 2003 and is projected to be 208.0 for 2004. The 2002 incidence

rate for gonorrhea was 22.9, this climbed to 26.0 in 2003, and is projected as 27.9 in 2004. In addition to these two other STIs, syphilis has also shown an increase. Although the rate is not high comparatively, it is more alarming because between 1996 and 2000 there was a 0.5 new infection rate per 100,000 individuals, but this rate steadily increased from 1.5 to 2.7 between 2001 and 2003 and has a projected rate of 3.8 for 2004. It is estimated that for HIV the number of new infections per year (2,800 –5,200) has remained stable since 2001. Health Canada (2004) has statistically calculated that 56,000 people in Canada live with HIV/AIDS and that roughly one third of these individuals are undiagnosed and thus unaware of their serological status. These undetected infections create a public health concern because these individuals could unknowingly and unintentionally transmit the virus to others. Approximately 44% of new HIV infections occur in MSM populations (Health Canada, 2003).

The Imperatives of Health

According to Lupton (1995), the Modern Public Health system resulted from increased urbanization and population density. Over time, however, it evolved into the intentional behavior modification for individuals to lead healthier lives. In other words, it has become the government of bodies through techniques that serve to engage individuals, groups, and/or communities in the internalization of health-improving behaviors. This is achieved through techniques such as empowerment, which provide an appearance of willing behavior modification while preventing the individual from feeling as if someone external to the self is in fact dictating the change (Gastaldo, 1997). Individuals must become masters of themselves by seeking to maximize their health and their quality of life. However, Lupton (1995) proposes that some individuals refuse this public health proposition and, in doing so, reside in the margins of society's accepted norms.

Determinants of Health

Because STIs can only be acquired through sexual practices, the first determinant of health for STIs is health practices. Within the scope of this article, only consensual sexual activities are evaluated. As a determinant of health, poor health practices are actions increasing the risk of contracting STIs, such as barebacking (voluntary unprotected sexual intercourse), number of partners, frequency of sex, penetration role, and anonymous encounters (Parsons, Halkitis, Wolitski, & Gomez, 2003). According to Lupton (1995), actions that may affect health are more than strictly actions–they are praxes (actions that are undertaken as an intentional manifestation of underlying thoughts and beliefs). To view sexual practices as actions undervalues their importance in human existence, and to view these actions as health practices is to take a practice that the individual quite possibly undertook without concern for health and to impose the current public health worldview upon it. Such a mislabeling constrains and disregards the initial significance of this action. Health practices are thus sexual practices and their associated risk factors for STI transmission that are undertaken as a result of health beliefs, income, social status, education, and available health services (Deleuze & Guattari, 1987). Therefore, it is the collisions of these determinants that produce the visible aspect of the health practices that become classified as low, medium, or high risk (Jagose, 1996).

Because health is highly subjective (Potter & Perry, 1997), and because sexual health is a fundamental aspect that defines the identity and subjectivity (Foucault, 1990) of certain cultures and subpopulations, such as hetero-, bi-, and homosexuals, this article proposes that the most important determinant of health related to sexual practices is culture. Briefly, in this context, culture is the composition of attitudes, beliefs and values of individuals as they apply to health (Shah, 2003). It is the proposition here that in regard to sexual health, the framework of an individual's culture should be drawn upon to guide the analysis of the subsequent determinants of health.

Although culture encompasses the notion that beliefs and values toward health are diverse (Shah, 2003), there is still of attachment to the mainstream "culture" of the supposedly universal underlying assumption that all individuals are ultimately self-motivated toward being healthy (Lupton, 1995). Using the work of Lupton (1995), the health determinant of culture is changed from the mainstream public health disquisition (defined here as the discourse that must be accepted) that individuals desire to be healthy. She illustrates that the Modern Public

Health system is an intentional "healthy" behavior modification of individuals: the regulation of bodies through a variety of methods to internalize health-improving activities to the point that self-control enables individuals to have power over their health (Lupton, 1995). The conscious seeking of health has become an imperative (Gastaldo, 1997; Gastaldo & Holmes, 1999; Holmes & Gastaldo, 2004).

However, Lupton (1995) states that some individuals reject (consciously or unconsciously) this public health ideology of the civilized individual and thus reside in the margins of society's sexual norms. Lupton purports that if individuals reject the majority status of the middle-class heterosexual (if the individual were to reject that which is "normal" for middle-class North Americans), then the mainstream public health discourse regarding safer sex practices, for the most part, will be nonapplicable to subpopulations who define their sexuality or their social status differently (1995), such as in the case of MSMs whose sexuality has been approached as a risk factor as opposed to a defining factor of their individuality (Holmes & Warner, 2005). By ignoring harm reduction strategies, the personal health practices of some members of these groups can be reframed as neither actively resistant nor ignorant but as praxes of their health beliefs (Deleuze & Guattari, 1987). As illustrated by recent studies, the sexual practices undertaken by some teens and MSMs reflect the group's culture, and regularly these norms do not align with the public health disquisition (Alderson, 2003). Furthermore, studies have indicated that many individuals not conforming to this majority group are less likely to follow the ideologies of self-control, making them less likely to be constrained in their actions (Foucault, 1995; Lupton, 1995). Evidence has illustrated that for teens and MSMs, sexual health knowledge is present but willfully disregarded (Holmes & Warner, 2005). In this case, sexual practices as a health determinant is the tip-of-the-iceberg produced in part by the underlying health culture of these at-risk groups.

The two determinants of gender and biology will be analyzed together as indistinguishable aspects of human identity that help create health practices. The sexual practice of being penetrated, whether by a penis or a sex-toy, puts one at higher risk of acquiring an STI (Grulich, 2000), explaining why gender and biology must be linked: biology is the anatomy and physiology of the human body, gender the biological and social construction of differences between males and females. Under the determinants of gender and biology, there is the aspect of inborn personality and physiological desires that combine with culture and other determinants to produce sexual practices. Power relations between males and females and younger versus older males have been linked to the subordinate members who are more likely to engage in sexual activities that they would not have chosen (Woody, D'Souza, & Russel, 2003).

Studies have also indicated that the two determinants of income/social status and education are implicated in sexual practices that result in higher STI rates. Although separate determinants, the findings of their significance have been similar and overlapping. Briefly, income/social status is "the most important determinant of health nationally" (Shah, 2003, p. 18), and education involves providing individuals with skills for job acquisition and daily task completion (Health Canada, 2003). Studies have demonstrated that for those who at times engage in survival sex or sex trade work, STI rates have been raised (Roy et al., 2004); however, both are beyond the scope of this article. For groups in the lower socioeconomic and education strata, studies have correlated both determinants and STI rates but simultaneously questioned the statistical significance of these findings (Roy, Haley, Leclerc, Sochanski, Boudreau & Boivin, 2004). Other studies have found no such correlation (Santelli, Lowry, Brener, & Robin, 2000). For example, in one study, individuals with lower education levels were less likely to undertake STI testing but were more likely to test positive when they did (CDC, 1993); however, the authors (1993) hesitated in concluding that education level produced the lower testing frequency or higher positive rates. In addition, Lupton's (1995) work provides alternative to reframe the practices of low-income, lower-education level individuals: as marginalized populations, these individuals feel less constrained by white, middle-class, heterosexist, public health mandates.

A final health determinant linked to STI rates is health services, with its underlying principle relying on the type of available service, not the number. For populations who hold cultural beliefs not coinciding with the public health safer sex disquisition, this determinant applies almost exclusively to the types of services available. As such, health services are

addressed in the health policy section because its effects on health are more dependent on health policies, as it is health policies that determine the services that are offered within the available health services (Lupton, 1995). Therefore, this section is limited to a cursory outline of the types of services available.

In larger Canadian cities, confidential and anonymous testing can be available from general practitioners, drop-in clinics, and sexual health centers (SHCs). For confidential testing, regardless of private or public health insurance involvement, in the case of a positive test, the individual is linked with the test result and surveillance protocols are instituted. Anonymous testing, conversely, is performed with a number identifier and not the individual's name. If a test were to be positive, no record or follow-up would be done: the individual would be offered services, but if declined, no sanctions could be instituted to ensure compliance.

The Effects of Current Sexual Health Policies

Although various successful public health nursing harm-reduction interventions and policies have been instituted, many are still predicated on the mainstream mores that individuals desire to be healthy (Lupton, 1995). This has promoted a strategy of health education that designs services and interventions on the assumption that if individuals are properly educated regarding health risks they will make healthy choices (Lupton, 1995). Such a belief disregards findings that some teens and MSMs habitually disregard STI testing because of a distrust of government, a fear of breach of confidentiality, a destigmatization of STIs within this group, and a rejection of an imposing public health (Ford & English, 2002; Knight, 2004). In effect, policies based on this philosophy have caused victim blaming in which at-risk individuals are viewed as intentionally causing their own demise or death (Shah, 2003).

Health policymakers have instituted laws to track STI rates and STI services that are based on the seeming belief that if statistical evidence is properly correlated, interventions can be designed to address risky practices (Holmes & Warner, 2005). These assumption that nonhealth care individuals (laypersons) have the same health beliefs as health professionals and that individuals must engage in unhealthy practices out of ignorance create policies that unintentionally promote racism, sexism, and class disparities (Guba & Lincoln, 1998). Studies have shown that when proper pretest counseling for HIV has been done and the differences between confidential and anonymous testing have been explained, most individuals opted for anonymous testing (CDC, 1993). It has been found that if anonymous testing is not available after pretest counseling, individuals chose no testing over testing with a risk of a breach of confidentiality (Hertz-Picciotto, Lee, & Hoyo, 1996). It is interesting to note that no studies could be found in MEDLINE®, CIHNAL®, and ProQuest® searches on December 1, 2004, to directly correlate the effect of providing anonymous STI testing with testing frequency. However, that addressed the issue of non-HIV STIs and confidentiality these reported that any decrease in confidentiality would result in SHC stopping testing, but not the activities for which they access the services (Ford & English, 2002; CDC, 1993; Kovac, 1997). Although a disproportionate number of individuals refuse HIV screening when only confidential testing is available as opposed to anonymous testing, another major issue arises because a significantly low number of low-income individuals are aware of anonymous HIV testing (Hertz-Picciotto, Lee, & Hoyo, 1996).

As a glaring example of health policies maintaining class disparities, a larger proportion of well-educated individuals engage in HIV testing, but only when anonymous testing is available (CDC, 1993). This is not due to socioeconomic status in itself, as it can be partially attributed to poorer and less well-educated individuals being unaware of anonymous testing because it is not well advertised and because they are less likely to challenge health professionals and request anonymous testing. Current practices are thus geared to mainstream society while disregarding at-risk groups who are more likely to be in need of sexual health services (Chen, Boree, & Kerndt, 2003).

Potential Points of Intervention

The first point of intervention proposed here is the reconceptualization of sexual practices away from

the moralistic public health discourse that proposes particular sexual practices, to a "new" public health that includes as a part of its strategy a more inclusive sexual health discourse that hopefully increases the target population being reached by health messaging. Such a reframing does not mean that public health has not historically addressed risky behavior, but that when it has, it has addressed the practices in a moralistic manner, such as the promiscuity paradigm in which partner number is more important that sexual activity and precautions taken with each partner. This reframing would require the acceptance by health professionals that health is not the driving force behind the practices of all individuals because while certain individuals are concerned with health, others are not. By increasing the scope of the fundamental philosophy of sexual health, it is hoped that providing services to individuals who engage in risky sexual practices will increase while simultaneously helping youth and MSMs gain a sense of legitimacy.

It is the proposition here that a lack of anonymous testing for high-risk individuals prevents many from accessing the available services. While at first glance, reducing surveillance appears to be counterintuitive, possibly this is what is needed when STI rates are at a record high. Because anonymous testing is available only for HIV, and it has been shown that in the case of HIV, individuals are less likely to be tested if the testing is exclusively confidential, a method to reduce STI rates would be to institute anonymous testing for all STIs. Although this could be viewed as decreasing surveillance while putting the public at greater risk, the reverse is more likely to occur. At present, individuals who are within the public health high-risk category, do not, for the most part, get testing until unpleasant clinical symptoms are present. Therefore, from the initial encounter when the individual became infected until the time when clinical symptoms develop, which could range from weeks for gonorrhea and chlamydia to months for syphilis, a larger number of other individuals could have engaged in sexual activities with this individual and thus have become infected themselves. It is essential to remember that such high-risk individuals refrain from testing for reasons of a lack of confidentiality within the current system. To reduce the number of partners between the time of infection and the time of testing, anonymous and nonjudgmental services could provide treatment before the infection is spread to others. This strategy reduces the amount of partner follow-up required by reducing beforehand the number of potential between the contact and the testing. Another argument for anonymous testing is that because individuals with higher levels of education and socioeconomic status are more likely to opt for anonymous HIV testing while refusing all other testing, current health care policies discriminate against those who are marginalized and maintain the status quo.

Conclusions

This article analyzed the determinants of health as they apply to sexual practices and STI transmission. Using the work of Lupton (1995), the determinants of health proposed by Health Canada (2002) are refocused with culture, gender/biology, income/social status, education, and health services positioned as the underlying aspects of health that produce health practices, which are visible to and classified by sexual health professionals. For public health nurses working in sexual health centers to provide culturally sensitive care to groups whose sexuality defines as at risk, a Canadian national standard might be implemented to ensure consistent STI surveillance and mandated anonymous testing. With such a framework, public health nurses could distance themselves from being part of an agency that has become detached from individuals through the use of group statistics (Lupton, 1995) and re-instill the "care" in public health care.

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