
Intimate Stories: Aboriginal Women's Lived Experiences of Health Services in Northern British Columbia and the Potential of Creative Arts to Raise Awareness About HPV, Cervical Cancer, and Screening

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ABSTRACT

Guided by feminist and community-based participatory methodologies and by efforts to decolonize health research practices, and undertaken with qualitative research methods (interviews, open-ended questionnaires, and analysis of arts-based expressions like storytelling, journaling, and picture-making), this research identified challenges and barriers that (predominantly Aboriginal) women in northern British Columbia faced when trying to access sexual health care services related to HPV and cervical cancer screening. The research also examined the possible effectiveness of creative or arts-based strategies to promote cervical health and screening awareness among young and/or traditionally underserved or marginalized women. We review findings from data gathered over six months during multiple interactions with 22 women from a wide range of ethnic backgrounds. Results confirm that ethnicity, finances, and formal education are determinants in women's awareness about, access to, and use of cervical screening services, and that experiences of gendered victimization, feelings of disempowerment, and life circumstances all influenced women's comfort levels with, access to, and use of cervical cancer screening services.

KEYWORDS

Sexual health promotion, creative art(s), HPV, cervical cancer, Aboriginal women, community-based approaches



INTRODUCTION

Dee,¹ who was born in British Columbia's interior, is a middle-aged Cree Métis woman raised by multiple foster families in northern British Columbia. Dee's history is not uncommon: Aboriginal children make up 40% of children in care, while only representing 6% of the total population of children in British Columbia (BC Aboriginal Childcare Society, 2007). The Northern Health Authority has the highest percentage of Aboriginal people in the province, translating into significant numbers of people who have experienced state intervention at the family and individual levels (Blackstock, 2007, 2011). Due to ongoing abuse inflicted on her as a child, Dee left "home" at the age of 14 to live on the streets. She worked in the survival sex trade industry for most of her teen and adult life while simultaneously struggling with addiction issues and repeated victimization. When asked about her relationship with physicians², Dee spoke about a particular moment that has stayed with her: "He looked at me like I was a junkie... he doesn't have to say anything. All he has to do is look at you and like, we are from the streets—we can read every little thing you do, right?" (Dee, personal communication, June 2010). For Dee, that single interaction affected the future of her health care, particularly health care involving what she described as "intimate" care (i.e., sexual health, HPV, and Papanicolaou [Pap] smears).

Dee is not alone in being an Aboriginal woman whose life circumstances (which, as this paper explores, are in part determined by a series of sociocultural and economic drivers, including colonialism) result in a disconnect with the health

system that, in great part, hold the potential to impact rates of HPV infection and cervical cancer. Understanding the challenges that women with similar life circumstances to Dee face, and then theorizing how to bridge the disconnect between women like Dee and the health care system, was the goal of research explored in this paper.

BACKGROUND

Aboriginal people's health is deeply impacted by social determinants (Loppie-Reading & Wien, 2009; Hankivsky & Chrisoffersen, 2008; Marmot et al., 2008) including colonization and its resultant intergenerational traumas. Colonial encounters have resulted in many Aboriginal people feeling mistrust or alienation toward "Western" or non-Aboriginal structures, including the medical system (Provincial Health Officer of British Columbia, 2009; Thibodeau & Peigan, 2007; Richmond & Ross, 2009; Reading, Kmetc, & Giddion, 2007; Smylie, 2009; de Leeuw, et al., in press). This feeling of alienation can stand in the way of Aboriginal people using services or feeling confident in fully expressing an array of health needs to health care providers. Aboriginal people also often encounter a health care system insensitive to their unique health needs and experience the naïveté of many (particularly non-Aboriginal) health care providers about realities specific to Aboriginal people (Adelson, 2005; de Leeuw & Greenwood, 2011; Elliot & de Leeuw, 2009).

The challenges faced by Aboriginal people in accessing health services are exacerbated in northern British Columbia. British Columbia is home to 198 separate and unique First Nations, the highest number of distinct communities in comparison to all other provinces and territories in Canada. Aboriginal people in British Columbia represent approximately 4.8% of the total population (Province of British Columbia, 2008) and approximately one-third of Aboriginal people in British Columbia live in the northern areas of the province (British Columbia, 2009). In British Columbia, mortality from cervical cancer was significantly higher among Status Indian women compared to other women for the period 2002 to 2006, which is three times the rate of all other residents (British Columbia, 2009). This research took place in the Northern Health Authority, which has higher relative incidence rates and hazards associated with cervical cancer than all other health authorities in the province (BC Cancer Agency, 2007).

¹ Like all participant names in this paper, "Dee" is a self-selected pseudonym and not the participant's real name. The research was approved by the University of Northern British Columbia's Research Ethics Board (REB) and supported by the organizations from which many of the participants were recruited.

² Research questions included: (a) What is your comfort level with physicians? (b) Describe what the word "trust" means to you, (c) Do you trust health care professionals... why or why not? and (d) Please describe your comfort of your last Pap smear. This research is not, however, meant to guide clinical policies or physician practices. Nor is the research meant to be reproducible or generalizable. It is a (principally) qualitative inquiry into a small population's experience around accessing sexual health services, notably those linked to cervical cancer screening and HPV prevention. We believe the in-depth and experiential nature of participants' stories can serve to illuminate broader discussions about how to make cervical cancer screening and HPV prevention strategies more relevant to and respectful of multiply marginalized Aboriginal women.



RESEARCH METHODOLOGIES AND METHODS

Decolonizing, anti-racist, and feminist research methodologies, in addition to intersectionality theory and social determinants of health perspectives, have recently compelled health researchers—particularly health researchers focused upon Aboriginal peoples and communities—to conceptualize and undertake health research in new ways (Green 2007; Hankivsky & Chrisoffersen, 2008, Smith, 1999). There is awareness that research must account for its role in (re)producing social inequities and that (particularly women's) health is intimately linked with broader sociocultural systems of power (Brown & Strega, 2005; Green, 2007; Smith, 1999; Wilson, 2008). With these methodological imperatives in mind, and as feminist researchers, one of whom is a young Aboriginal woman, we wanted to understand how women in our community experienced their “health worlds.” Consequently, and in line with community-based research principles (Brown, 1991; Brown & Strega, 2005; Christopher et al., 2008; Grunfeld, 1997), we invested time to build relationships within the community where we undertook research and worked with young women in the community to create health education workshops about cervical cancer³. The success of using community-based participatory research (CBPR) approaches to health problems has been well-documented, particularly when working with marginalized populations (Brown, 1991; Brown & Strega, 2005; Grunfeld, 1997).

Feminist methodologies acknowledge that research should be *for* and *by* women rather than *on* or *about* women (Ironstone-Catterall, et al. n.d). As a result, our research aimed to be inclusive of voices that are often silenced (e.g., women in the sex trade industry), was conscious about the need to build capacity in the women with whom we worked, and resulted in usable information that participants took ownership of. Specific to marginalized women and cervical

³ In order to ensure commitment to the research context, one of the authors became an active board of directors member in a local not-for-profit society focused exclusively on working with survival sex trade workers in Prince George. The other author, in addition to a two decade-long involvement in northern women's groups and work with women in prisons, sits as a member of the local Elizabeth Fry Society in Prince George, which works with multiply marginalized women in the community.

cancer prevention, Christopher et al. (2008) demonstrated the importance and success of a community partnership intervention approach, rather than the traditional public health approach that they argue “ignore[s] a substantial part of the dynamic and social nature of public health programs” (p. 831). Engaging in CBPR provides opportunities for women who are vulnerable to develop skills and achieve a sense of self and ability concerning improving important health issues both within their community and within their own lives (Brown & Strega, 2005; Christopher et al., 2008). Methodologically, we acknowledge the importance of using an equity-based or social justice framework for research and then advocating for the emancipation from social oppression, marginalization, and stereotyping in society and health care. By listening to women's stories, whether through questionnaires, journals, photos, storytelling, or art, we were able to better understand some of the barriers women feel they face in access to or use of cervical screening.

Prevention of cervical cancer rests on early detection, which relies on holistic and culturally appropriate education strategies (Bigby et al., 2003; Shoveller, Chabot, Soon, & Levine, 2007; Shoveller et al., 2009). This requires listening to women about raising awareness about HPV and cervical cancer (Barnett & Shoveller, 2011). We undertook a six month-long community-based research project organized into three stages. The first stage focused on building understanding about research. The second stage involved gathering information about levels of understanding about HPV by participants, all of whom were traditionally marginalized women. The third stage focused on assessing how best to raise awareness among traditionally marginalized women about HPV and cervical cancer. In adherence to a community-based research model, and with a commitment both to building capacity and to working *with* as opposed to *on* the participants, we trained four women as research assistants and community educators.

Women were recruited during the first stage of the project, primarily by word of mouth, from the New Hope Society (a non-profit drop-in centre and safe space for women working in the survival sex trade industry), and the Elizabeth Fry Society (an organization dedicated to working with women at-risk for criminalization and/or victimization). Although participants did come from outside these two organizations, most had connections with women who accessed the two agencies. In the first stage, women completed questionnaires that explored their understanding about health determinants and their medical and Pap smear history, as well as their experiences with and perceptions about the health care system. Stage two entailed recruiting



women from the community interested in attending six months of regularly scheduled arts-focused group workshops with discussions about cervical health. If needed, attendees were provided with childcare and transportation; snacks, beverages, and remuneration for women's time were also provided. The purpose of group sessions was both to document if women's awareness about cervical cancer and research techniques increased through creative art engagement, and to better understand women's lives and lived experiences in relation to sexual health, the health care system, and HPV and cervical cancer. Participants learned about HPV, cervical cancer and screening and, with the intent to build future capacity and make the research useful to a broader community, prepared to lead other arts-based workshops. Finally, in stage three, women took part in two peer-led and arts-based cervical health community workshops during "Pap Awareness Week," a promotional initiative of the Cervical Cancer Screening Program "Live Aware. Create Empowerment." (LACE) Campaign.

In total, five data sets were combined for qualitative analyses to yield the research results explored in this paper. Data sets included hand-written and transcribed notes from the twenty-two women who completed questionnaires, three journals ranging from 14 to 28 pages in length, 52 photos taken by group members, one recorded women's health group discussion, and 34 art pieces made by participants. During the first stage of the research, numerical data gathered from the questionnaires was entered into a statistical analysis program (Statistical Package for the Social Science [SPSS]) and later analyzed using this program. Demographics and aspects of participants' lives, such as self-reported health, stress, financial positions, cervical cancer screening use, levels of trust comfort and awareness about HPV, and cervical cancer scores, were generated using SPSS. Once the project was complete in November, 2010, coding ensued by combining the data sets and using a thematic approach (Braun & Clarke, 2006; Aronson, 1994) to generate themes, with particular attention to women's awareness about cervical health and barriers to use of or access to cervical screening. Women's stories were then pieced together to form a comprehensive picture of their collective experiences (Aronson, 1994). For validation, the findings from the qualitative data were reviewed and agreed upon by two of the women who regularly participated in the women's health group.

RESULTS AND DISCUSSION

Demographics

A total of 22 women aged 19–29 and two women aged 45–56 years filled out questionnaires during the first stage of the project. Fifteen women self-identified as having Aboriginal heritage including two Métis women, one Cherokee woman, and 12 women from the following communities: Takla, Lake Babine (Nat'oot'en), Sechelt (Shíshálh), Horse Lake, Stoney Creek (Saik'uz), Kwadacha (Tsek'ene), and Nakazdli First Nations. Seven of these women explicitly identified themselves as having First Nations status. Four women participated in stage two of the project, which involved monthly arts-based cervical health groups (sexual health awareness training) for six months.

Comfort with health care providers

Of the 22 women, 15 had a regular family physician and seven women did not. Six of the seven Status First Nations women did not have a regular health care provider. The length of time spent as a patient with family physicians varied between one and 23 years ($M = 9.64$, $SD = 8.1$, $Mdn = 7$). The comfort experienced with family physicians also varied among each woman. Three women said they felt "extremely low" or "below average" levels of comfort with their family physician. Six felt "average" levels of comfort, four felt "above average," and three felt "extremely comfortable" with their family physicians. When asked, 14 women said they had a general trust of health care professionals while eight said they did not.

Cervical cancer screening use

Twenty research participants had participated in cervical cancer screening services at least once in their lifetime while two never had. The regularity of women's participation in screening varied. Many women (11) said they were screened yearly. One woman went in "every six months" and four went "every two years." One woman said her last Pap smear took place "too long ago to remember" and five women said they had "rarely" or "never" had a Pap smear: cervical screening had occurred once, more than 3 years ago. Comfort with the last Pap smear varied: six of the women had "extremely low" levels of comfort during their last Pap smear, five women experienced "below average" levels of comfort, and nine women felt "average," "above average," or "extremely high" levels of comfort.



Awareness about HPV and cervical cancer

Women's awareness about HPV and cervical cancer was assessed using a series of eight "true" or "false" statements about HPV and/or cervical cancer. Women were asked to answer "true," "false" or a use question mark (?) if they were not sure what the answer was. We also wanted to know if formal education played a role in women's awareness about these sexual health topics. Results are displayed in Table 1 with the frequency and percent of correct and incorrect responses received for each statement.

Half of the participants knew that HPV can cause cervical cancer, while the other half were not sure of the relationship between HPV and cervical cancer. Women indicated low levels of awareness, in general, about HPV including its asymptomatic nature (59% incorrect) and the existence of various strains (50% incorrect). The cumulative awareness scores for the women ranged from 0 to 8. Five women answered all eight questions correctly. Two women answered seven questions correctly, while 12 women answered four or fewer questions correctly. Of the 13 women with below high school education levels, an average of 2.85 ($SD = 2.5$) questions were answered correctly. Participants with high school level-education and above answered an average of 6.44 ($SD = 1.7$) questions correctly. Women in this project with higher levels of formal education had higher levels of awareness about HPV and cervical cancer. However, in general women who participated in the questionnaire had somewhat low awareness about HPV.

Post-workshop HPV awareness

Before and after questionnaires were also filled out by women participating in stage two (group workshops) of the research who had not participated in stage one (awareness building). The scores from both data sets—women who had also participated in stage one ($n = 8$) and additional women who attended the workshops ($n = 11$)—were combined ($N = 19$). Women's scores pre-workshop ($M = 4.39$, $SD = 2.89$) significantly improved after attending ($M = 7.16$, $SD = 1.61$), indicating that women's awareness about HPV and cervical cancer significantly improved after attending an arts-based workshop. Most tellingly, the statement "HPV can cause cervical cancer" was answered incorrectly by half of the women before attending the group workshops. After the workshops, only one woman answered this question incorrectly.

Themes

Using thematic analysis and the theoretical frameworks mentioned above, four relevant and validated themes emerged from the data: (a) experiences of gendered victimization, (b) feelings of (dis)empowerment, (c) life circumstances, and (d) lack of awareness. These had an impact on all aspects of women's interactions with HPV and screening opportunities, shedding light on barriers women experience when accessing services that could prevent cervical cancer.

Experiences of gendered victimization

Thirteen women spoke, wrote, or made art about experiences with victimization and directly related them to (dis)comfort receiving sexual health information and HPV screening services from health care professionals. Women's stories of victimization included discussions about emotional, physical, and sexual abuse ranging from childhood to current day. Patricia describes Pap smears as "the worst thing you can get done" (Patricia, personal communication, June 2010). Petra, who had recently moved to northern British Columbia from her community, spoke about childhood episodes that made her feel distrustful. Although Petra had been with the same family doctor for about 10 years, she says that trust is "sacred" and that she did not trust anyone, "not even my own doctor." Petra was sexually molested when she was seven years old and spoke about how this contributed to her discomfort with her physician, particularly having Pap smears: "I was molested when I was younger; my discomfort has got a lot to do with somebody just touching me" (Petra, personal communication, June 2010). Sharon also talked about a traumatic childhood. She ran away from home when she was 11 years old because of the physical and sexual abuse. At 14 years of age, she began "working the streets," observing she had a "long history of addictions." She describes trust as "loyalty... just believing in someone... having faith", of which she says she has "very little." "I've learned the hard way," said Sharon, "[that] on the streets there is really nobody to trust. I trusted a lot of people in my life and a lot of shit has happened to me" (Sharon, personal communication, June 2010). Consequently, Sharon also says that she does not trust health care professionals. The last Pap smear that Sharon received was during a mandatory examination at a treatment centre. She had never self-initiated a Pap smear.

Broad agreement existed among women that (a) women were commonly victims of abuse in a variety of forms, (b) these experiences have enormous impact on women's



TABLE 1. QUESTIONNAIRE: AWARENESS ABOUT HPV AND CERVICAL CANCER ($N = 22$)

Statements	Correct (%)	Incorrect (%)
"The only symptoms of HPV are genital warts"	12 (54.5)	10 (45.5)
"You can always tell if you have an STD without seeing a doctor"	17 (77.3)	5 (22.7)
"HPV can have no symptoms"	10 (45.5)	12 (54.5)
"Sometimes you can't tell if you have HPV"	9 (40.9)	13 (59.1)
"Different strains of the HPV can cause different symptoms"	11 (50)	11 (50)
"If your partner has had an STD check, no condom is OK"	16 (72.2)	6 (27.3)
"HPV can cause cervical cancer"	11 (50)	11 (50)
"HPV can be asymptomatic"	9 (40.9)	13 (59.1)

formation of trusting relationships, and (c) cervical cancer screening, due to its highly intimate nature, requires trust and is used less often and with much less comfort when there is a lack of trust or a male doctor: "So many women that I know don't go for Pap smears because of the lack of female doctors. . . . Women are lagging for so many reasons and some of them are just not in their hands, really" (Ann, personal communication, June 2010). A large proportion of women, particularly Aboriginal women, have experienced victimization (Brennan, 2011; Perreault, 2011). It is extremely important that health professionals account for experiences of victimization when providing services. Continuity of care was an important aspect for women undergoing cervical cancer screening. They needed to build trusting relationships and ultimately feel more comfortable with their health care professionals when either accessing information or having a Pap smear, and this too must be accounted for.

Feelings of (dis)empowerment

The second theme that emerged was that of (dis)empowerment. Women felt disempowered or disadvantaged because power relations shaped their choices and opportunities in health care. They described events in which they felt ignored by their physicians while presenting concerns and spoke of not being listened to about their treatment options. Some women felt their health care professionals dissuaded them from accessing health services. Cadence, a 28 year-old First Nations women said she "kept trying to talk to them [the nurses and doctors at a local health centre] but they wouldn't even try to help or nothing"

(Cadence, personal communication, June, 2010). Cadence felt powerless about health decisions being made about her, which continues to affect her. Deb works in the survival sex-trade industry and has a long history of addictions. She told a similar story and observes that stereotyping affects women's care:

It's almost like a lot of these doctors now are labeling people so no one wants to give anyone a hand, right? I'm trying to heal myself and get places, but I can't if my physician is not standing behind me. . . . I notice a lot of girls on the street have a fear of speaking up (Deb, personal communication, July 2010).

Patricia's trust toward her family doctors is "extremely low" because she does not feel her needs were being met or her voice heard. During a recent appointment, she requested a conversation with her physician about decreasing her antidepressant dosage. She said her physician refused and insisted to her, "You need to be on them" (Patricia, personal communication, June, 2010). As a result, Patricia took herself off the medication and had been experiencing adverse side effects such as extreme anxiety. Negative interactions with a health care professional commonly resulted in reduced access to sexual health information, lowered use of screening services, and/or nonadherence to medication.

Life circumstances

Life circumstances emerged as a third cause of challenges women faced in accessing and using health care services.



These included lack of transportation, parenting, and childcare. Of the 22 women who filled out the questionnaire, seven said they did not have reliable transportation, a critical component of women's lives in northern geographies (Thien & Hanlon, 2009). Of the 13 mothers who completed the questionnaire, seven were single parents, three of whom said they did not have reliable and/or trustworthy childcare for their children.

Tracy, a mother of two young children who relies on public transit, talked about the unreliability of the transit system: "Buses don't run often enough, early or late enough, or have enough routes" (Tracy, personal communication, November 2010). Accessing health services was considerably more difficult for women during harsh winter conditions. Mickey, a 25-year-old Aboriginal woman and single parent of three, said "transportation is one of the biggest issues," or barriers, (Mickey, personal communication, June 2010) she faces in access to sexual health services and education. Ann, a single parent of three children all under the age of six years, also says she feels enormous life circumstances pressures. She parents her children alone, and receives no financial support from the children's father. During the research project her basic home services (including telephone and power) were disconnected. She had been given an eviction warning from her landlord, as she had not had the finances available to pay her rent on time. She felt like she was "drowning" in responsibilities. Chantal, a mother of four children, had stress associated with single parenting: "I haven't had a good break for a long time. My husband took off on me, this is the fourth time he did this to me. . . That's why my kids were taken away overnight. . . This is what stress is to me" (Chantal, personal communication, August 2010). Transportation, parenting, and childcare are important in women's ability to attend or participate in a plethora of activities, including health care education and services. Finances played an important role in women's ability to take a break from parenting and access to reliable transportation. Having access to reliable, trustworthy, and affordable childcare, therefore, is extremely important to increasing cervical screening services use for young and/or vulnerable women with children. Good transportation and supported childcare also reduces levels of stress, a known predictor of better overall health.

Lack of awareness

Women who participated in the research project, as well as their friends and family, had fairly low levels of awareness and expressed confusion about HPV, cervical cancer, and

screening. Ann wrote in her journal: "I want to learn more about HPV and women's health because it isn't something that I have talked about with anybody, so I don't understand much about HPV or any other things about sexual health" (2010, p. 1). Similarly, Tracy wrote: "One of my hopes with this project is to learn a bit more about women's health and wellness. Just by the first meeting I realized how much I didn't know" (2010, p. 2). Ann said she spoke to a woman who had very little understanding about HPV, did not know the reason behind having Pap smears, and felt confused about the vaccine:

Most women didn't even know the purpose of a Pap smear. Most women only get checked because they are told to by doctors. The importance of the Pap smear is not even discussed. Also the HPV vaccine that's available. . . most parents didn't even know what it's for or what it does (2010, p. 9).

Like other participants, Tracy knew little about HPV: "I never heard anything before reading about it now, this stuff. You don't hear it advertised that men carry it at all" (Tracy, personal communication, July 2010). During the same group meeting, Ann described a recent talk that had taken place with her family members: "Pretty much every woman that I spoke to, like there are a lot of women in my family that I spoke to about HPV and all that, knew nothing about it" (Ann, personal communication, July 2010). Women who took part in this research commonly expressed a lack of awareness about HPV and, in particular, the asymptomatic and contagious nature of HPV and its relationship to cervical cancer. Women felt that increased understanding about these sexual health issues would make women feel empowered, an important factor in women's comfort with and decision to have Pap smears.

CONCLUSIONS AND RECOMMENDATIONS

This research arose from concerns that inequitable access to information and use of primary sexual health services existed for women inhabiting northern, racialized, and impoverished marginalized geographies. Feminist and anti-racist methodologies, intersectionality theory, and social determinants of health perspectives underpinned the ways the project was planned and conducted. Overwhelmingly, social determinants including ethnicity, sociocultural and



spatial locale, education, and poverty had an impact on women's lives. Multiply marginalized women represented the highest proportion of those who did not trust health care professionals. Distrust correlated with lower levels of awareness about HPV and cervical health and lowered usage of screening services. Experiences with victimization were commonly associated with low levels of comfort and trust. Women wanted to feel listened to, respected, and in charge of their health decisions.

Research results demonstrated that low levels of awareness about sexual health topics like HPV and cervical screening existed before the community- and arts-based training and workshops were offered. Women in the project used the arts (e.g., journaling, photography, collage, and painting) to participate in a dialogue about their realities, lives, and lived experiences. After having engaged the issues through art-based means, women reported feeling "empowered" and "more comfortable" about having Pap smears. Women's levels of awareness about HPV and cervical cancer also improved after participating in art-centered endeavours, demonstrating the power of the arts, storytelling, and personal connections in the formation of trusting relationships needed to normalize traditionally "taboo" sexual health subjects.

Low levels of awareness about HPV, cervical cancer and use of screening is—especially for multiply marginalized and Aboriginal women—an important public health issue that must be addressed. Increased public sexual health education is needed for vulnerable women. Employing creative and/or holistic approaches to understanding, listening, and teaching is an underutilized and under-theorized method with great potential, particularly for Aboriginal women and within Aboriginal communities where creative traditions may represent culturally appropriate strategies. There is a need for Aboriginal-specific cultural sensitivity when working with women who have experienced victimization, more female health care professionals, continuity of care among health providers, and pragmatic services such as child care and transportation to increase women's Pap smear participation, particularly in northern landscapes and geographies with large numbers of Aboriginal women. We believe the women in this research are worth it.

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REFERENCES

- Adelson, N. (2005). The embodiment of inequalities: Health disparities in Aboriginal Canada. *Canadian Journal of Public Health, 96*, 45–61.
- Ann. (2010). [Journal]. Copy in possession of the author.
- Aronson, J. (1994, Spring). A pragmatic view of thematic analysis. *The Qualitative Report, 2*(1). Retrieved July 22, 2011 from <http://www.nova.edu/ssss/QR/BackIssues/QR2-1/aronson.html>
- Band, P., Gallagher, R., Threlfall, W., Hislop, T., Deschamps, M., & Smith, J. (1992). Rate of death from cervical cancer among native Indian women in British Columbia. *Canadian Medical Association Journal, 147*(12), 1802–1804.
- Barnett, R., & Shoveller, J. (2011). *Cervical cancer: New technologies offer opportunities for prevention, but women's voices are missing from policies and programs*. The Canadian Women's Health Network (CWHN). Retrieved February 26, 2011 from <http://www.cwhn.ca/resources/cancer/cervical>.
- BC Aboriginal Childcare Society. (2007). *Steps in the right direction: Connecting & Collaborating in Early Intervention Therapy with Aboriginal Families & Communities in British Columbia*. Retrieved July 10, 2011 from http://www.acc-society.bc.ca/files_new/documents/StepsintheRightDirection2007.pdf.
- BC Cancer Agency (2007). *Regional Cancer Statistics 2007* (The Surveillance and Outcomes Unit: Population Oncology). Retrieved September 14, 2011 from http://www.bccancer.bc.ca/NR/rdonlyres/910907D3-23C1-40B6-896E-AC99348760A4/43234/Regional_Cancer_Stats_rerun2007.pdf.
- Bigby, J, Ko, L., Johnson, N., David, M., & Ferrer, B. (2003). A community approach to addressing excess breast and cervical cancer mortality among women of African descent in Boston. *Public Health Report*, vol. 118.
- Blackstock, C. (2007). Residential schools: Did they close or just morph into child welfare. *Indigenous Law Journal, 6*(1), 71–78.
- Blackstock, C. (2011). Why if Canada wins, Canadians lose: The Canadian Human Rights Tribunal on First Nations Child Welfare. *Children and Youth Services Review, 33*, 187–194.
- Boisaubin, E. V., & Winkler, M. G. (2000). Seeing patients and life contexts: the visual arts in medical education. *American Journal of Medical Science, 319*(5), 292–296.



- Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, 3, 77–101.
- Brennan, S. (2011). “Violent victimization of Aboriginal women in the Canadian provinces, 2009.” *Juristat*. May. Statistics Canada Catalogue no. 85-002-XWE. Retrieved July 16, 2011 from <http://www.statcan.gc.ca/pub/85-002-x/2011001/article/11439-eng.pdf>.
- British Columbia. (2008). *The Diversity of Ethnic Minorities and Ethnic Origins in British Columbia*. Victoria, British Columbia: Ministry of Attorney General. Retrieved July 14, 2011 from http://www.llbc.leg.bc.ca/public/pubdocs/bcdocs/444122/visible_minorities_ethnic_origins.pdf.
- British Columbia. (2009). *Pathways to Health and Healing—2nd Report on the Health and Well-being of Aboriginal People in British Columbia. Provincial Health Officer’s Annual Report 2007*. Victoria, British Columbia: Ministry of Healthy Living and Sport.
- Brown, L. & Strega, S. (2005). *Research as resistance: Critical, Indigenous, & Anti-oppressive approaches*. Toronto: Canadian Scholars’ Press.
- Brown, R. (1991). Community action for health promotion: A strategy to empower individuals and communities. *International Journal of Health Services*, 21(3), 441–456.
- Christopher, S., Gidley, A., Letiecq, B., Smith, A., & McCormick, A. (2008). A cervical cancer community-based participatory research project in a Native American community, *Health Education & Behavior*, 35(6), 821–834.
- Cropley, A. (2001). *Creativity in Education and Learning: A Guide for Teachers and Educators*. Oxon: Routledge Falmer.
- de Leeuw, S., Maurice, M., Holyk, T., Greenwood, M. & Adam, W. (in press). With Reserves: The Geographies of Colonialism and First Nations Health in Northern-Interior British Columbia. *The Annals of the American Association of Geographers*. Health (special edition).
- de Leeuw, S., & Greenwood, M. (2011). Beyond borders and boundaries: Addressing Indigenous health inequities in Canada through theories and methods of intersectionality. In O. Hankivsky (Ed.), *Health Inequalities in Canada: intersectional Frameworks and Practices*, 53–70. Vancouver, British Columbia: UBritish Columbia Press.
- Dei, G.J. (2005). Critical issues in anti-racist research methodologies. In G.J. Dei, & G.S. Johal, (Eds.), *Critical Issues in anti-racist research methodologies*. New York: Peterlang Publishing Inc.
- Elliot C., & de Leeuw S. (2009). Our Aboriginal relations: When family doctors and Aboriginal patients meet. *The Canadian Family Physician*, 55, 443–444.
- Evans J. D., Crooks, V., & Kingsbury P. T. (2009). Theoretical injections: On the therapeutic aesthetics of medical spaces. *Social Science and Medicine*, 10, 1016.
- Graveline, F.J. (2004). *Healing Wounded Hearts*. Winnipeg: Fernwood Publishing.
- Green, J. (2007). *Making space for Indigenous Feminism*. Winnipeg: Fernwood Publishing.
- Grunfeld, E. (1997). Cervical cancer: Screening hard-to-reach groups. *Canadian Medical Association Journal*, 157, 543–545.
- Hankivsky, O., & Christoffersen, A. (2008). Intersectionality and the determinants of health: A Canadian perspective. *Critical Public Health*, 18(3), 271–283.
- Hyman, I. (2009). Racism as a Determinant of Immigrant Health. Public Health Agency of Canada. Retrieved September 14, 2011 from: http://canada.metropolis.net/pdfs/racism_policy_brief_e.pdf.
- Ironstone-Catterall, P., McDonough, P., Robertson, A., Payne, B., et al., (n.d). Feminist Research Methodology and Women’s Health: A Literature Review. Retrieved January 3, 2011 from <http://www.cewh-cesf.ca/PDF/nnewh/feminist-research-meth.pdf>.
- Kirmayer, L. J., Simpson, C., & Cargo, M. (2003). Healing traditions: Cultural, community and mental health promotion with Canadian aboriginal peoples. *Australian Psychiatry*, 11, 15–23.
- Kunz, J. L., Milan, A., & Schetagne, S. (2000). *Unequal Access: A Canadian Profile of Racial Differences in Education, Employment and Income*. A Report Prepared for the Canadian Race Relations Foundation by the Canadian Council on Social Development. Ottawa: Canadian Race Relations Foundation.
- Leavy, P. (2009). *Method meets art: Arts-based research practice*. New York: The Guilford Press.
- Marino, D. (1998). *Wild Garden: Art, Education, and the Culture of Resistance*. Between the Lines: Toronto, ON.
- Marmot, M., Friel, R., Bell, T. Howeling, & Taylor, S. (2008). Closing the gap in a generation: Health equity through action on the social determinants of health. *Lancet*, 372, 1661–1669.



- National Collaborating Centre for Aboriginal Health (NCCAHA). (2009). *Health Inequities and Social Determinants of Aboriginal Peoples' Health*. Prince George, BC: Loppie-Reading, C. & Wien, F. Retrieved July 12, 2011 from http://www.nccah-ccnsa.ca/docs/social%20determinates/NCCAHA-Loppie-Wien_Report.pdf.
- Native Women's Association of Canada. (2007). *Social determinants of health and Canada's Aboriginal women: NWAC's Submission to the World Health Organization's Commission on the Social Determinants of Health*. Retrieved July 12, 2011 from: http://www.nwac.ca/sites/default/files/reports/NWAC-WHO-CSDH_Submission2007-06-04.pdf.
- Parr, H. (2006). Mental health, the arts and belongings. *Transactions of the Institute of British Geographer*, 31, 150–166.
- Perreault, Samuel. (2011). "Violent victimization of Aboriginal people in the Canadian provinces, 2009." *Juristat*, Vol. 30, no. 4. Statistics Canada Catalogue no. 85-002-XWE. Retrieved July 18, 2011 from <http://www.statcan.gc.ca/pub/85-002-x/2011001/article/11415-eng.pdf>.
- Quan, H., Fong, A., De Coster, C., Wang, J., Musto, R., Noseworthy, T., & Ghali, W. (2006). Variation in health services utilization among ethnic populations. *Canadian Medical Association Journal*, 174(6), 787–791.
- Reading, J., Kmetc, A., Gideon, V. (2007). *First Nations Holistic Policy and Planning Model: Discussion for the World Health Organization Commission on Social Determinant of Health*. Ottawa: Assembly of First Nations.
- Richmond, C. M., & Ross, N. A. (2009). The determinants of First Nation and Inuit health: A critical population approach. *Health and Place*, 15, 403–411.
- Shoveller J., Johnson J., Rosenberg, M., Greaves, L., Patrick D., Olyffe J., & Knight, R. (2009). Youth's experiences with STI testing in four communities in British Columbia, Canada. *Sexually Transmitted Infections*, 85(5), 397–401.
- Shoveller, J., Chabot, C., Soon, J., & Levine, M. (2007). Identifying barriers to emergency contraception use among young women from various sociocultural groups in British Columbia, Canada. *Perspectives on Sexual and Reproductive Health*, 3(1), 13–20.
- Smith, L. T. (1999). *Decolonizing methodologies: Research and Indigenous Peoples*. London: Zen.
- Smylie, J. (2001). A guide for health care professionals working with Aboriginal people: A society of obstetricians and gynecologists policy statement. *Journal of Obstetrics and Gynaecology Canada*, 23(3), 255–61.
- Smylie, J. (2009). The Health of Aboriginal Peoples. In Raphael, D. (Ed.). *Social Determinants of Health: Canadian Perspectives*. (pp. 280-301), (2nd ed.). Toronto: Canadian Scholars Press, 280–301.
- Staricoff, R. L. (2006). Arts in health: the value of evaluation. *The Journal of the Royal Society for the Promotion of Health*, 126(3), 116–120.
- Thibodeau S., & Peigan, F. N. (2007). Loss of trust among First Nations people: Implications for implementing child protection treatment initiatives. *First Peoples Child and Family Review*, 3(4), 50–58.
- Thien, D., & Hanlon, N. (2009). Feminist perspectives on care and place. *Gender, Place & Culture*, 16(2), 155–162.
- Tracy. (2010). [Journal]. Copy in possession of the author.
- White, M. (2006). Establishing common ground in community-based arts in health. *The Journal of the Royal Society for the Promotion of Health*, 126(3), 128–133.
- Willson, S. (2006). What can the arts bring to medical training? *The Lancet*, 368(Suppl. 1), 15.
- Wilson, S. (2008). *Research is ceremony: Indigenous research methods*. Halifax: Fernwood Publishing San Francisco: Jossey-Bass.

