

ABORIGINAL WOMEN'S ACCESS AND ACCEPTANCE OF REPRODUCTIVE HEALTH CARE

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ABSTRACT

Aboriginal women are the life givers of our communities amongst a multitude of roles they employ throughout their lives. We need to work with Aboriginal women to address their disproportionate mortality rate for cervical cancer which is further complicated by jurisdictional issues in the health care system. This article focuses on the provision of culturally appropriate cervical cancer screening strategies with Aboriginal women through highlighting and discussing different cervical cancer screening programs available in Canada and the United States. Through these evidence based programs, we offer a flexible framework to gently guide you in the creation of a culturally sensitive cervical cancer screening program within your community with authentic Aboriginal peoples' partnership.

Keywords: Aboriginal women, cervical cancer screening strategies, culturally sensitive programming

INTRODUCTION

Women's health care needs have long been overlooked by a patriarchal society. There is no doubt that health screening has the potential to alert women and their care providers to life threatening diseases, allowing for early intervention and improved health outcomes. A better understanding of women's health care needs is required to provide a balance between biological knowledge and quality of life. To encourage health screening, consideration must be given to not only the implementation of screening protocols, but also to the factors that influence women's decision-making or access to services. Reproductive freedom includes a woman's right to choose what health screening to undergo as well as a right to choose how these services are offered. It has been suggested that women are aware of the importance of screening; however, services are not always offered in a way that is appealing. If appropriate services cannot be accessed, women can be labelled as noncompliant, disguising issues of inequity in the health sector. Accessibility to appropriate services is the real issue (Peters, 2010).

Reproductive health care for women includes cervical cancer screening (Pap tests), sexually transmitted infection (STI) screening and treatment, family planning, contraceptive counselling, and breast exams. This paper will focus on providing culturally appropriate cervical cancer screening to Aboriginal women with a goal of increasing screening rates; however, the principles developed and explored can be applied to all reproductive health services. First Nations, Inuit, and Métis peoples number over one million people in Canada. According to Elias et al. (2011) inadequate cervical screening

* The authors would like to thank the Assembly of First Nations, Native Women's Association of Canada, National Collaborating Centre for Aboriginal Health, and the National Aboriginal Health Organization as well as various other individuals for their research contributions which have shone a light on this important women's health issue. This paper uses the terms First Nations, Aboriginal, Indigenous, Native, and Anishnaabe interchangeably. This is due to differing terms used by other sources in this paper and also for space requirements. There are many nations across Canada, the United States, Australia, and the world that are distinct and should be respected as such. We acknowledge these different nations and respect each of them, although we regretfully cannot name them all individually.

programs have contributed to higher cancer mortality among Aboriginal women.

CERVICAL CANCER IN ABORIGINAL WOMEN: RATIONALE FOR CULTURALLY APPROPRIATE SUPPORT

Cervical cancer is diagnosed annually in approximately half a million women worldwide and about half will die from it (Duarte-Franco and Franco, 2003; NAHO, 2006). Preventing cancer of the cervix in Aboriginal women presents a challenge because there are lower rates of screening and poor attendance for follow-up of abnormal findings.

Early detection of cancer through screening of healthy populations has been proven effective in reducing mortality and morbidity from cervical, breast and colorectal cancers. (Assembly of First Nations, 2009)

Zehb et al. (2011, p. 2) reports that accessing health information and preventive medical services can be challenging for First Nation women — their communities are generally rural and remote, transportation is a limiting factor, and culturally appropriate, on-site health and educational services may be inadequate.

According to the First Nations Regional Longitudinal Health Survey (RHS, 2002/2003), conducted by the First Nations Information Governance Centre, the level of coverage and frequency of Pap smear testing amongst First Nations and Canadian women is remarkably similar. Given the disproportionate mortality rate First Nations women experience as a result of cervical cancer, more systematic First Nations-specific screening strategies would be advisable (RHS, 2002/2003, p. 125). Improving screening and prevention in the First Nations population requires funding commitments from federal and provincial health authorities, as well as on-reserve services (RHS, 2002/2003, p. 129). Indian and Northern Affairs Canada (1999) [now known as Aboriginal Affairs and Northern Development Canada] report that services for First Nations and Inuit are the responsibility of provincial, territorial,

and federal governments. The provinces/territories provide and/or pay for insured physician and hospital services; the federal government provides treatment and public health services in remote areas and public health services in nonisolated First Nation communities through the First Nations and Inuit Health Branch of Health Canada (INAC, 1999, p. 9). The current jurisdictional arrangement of health services creates conflicting views about constitutional responsibilities for Aboriginal health care which results in a confusing mix of federal, provincial, and territorial programs and services (Romanow, 2002, p. 212).

The Creator gifted women with the role of life-giver. This gift is honoured by maintaining the health and well-being of each woman and her family (Native Women's Association of Canada [NWAC], 2007). Although all women are entitled to culturally appropriate health promotion and prevention campaigns, the Aboriginal population is young and younger women are more susceptible to human papilloma virus (HPV), a precursor to cervical cancer (NAHO, 2006). Culturally sensitive screening strategies may assist with early detection, thus ensuring Aboriginal women fulfill their role as life giver and caretaker of their family, community, and nation.

The term "cultural sensitivity" will be used repeatedly throughout this paper which requires defining the difference between sensitivity and safety. Wepa (2003, p. 339) discusses cultural safety as a New Zealand term unique to nursing education which was born from the pain of the Maori experience of poor health care. Cultural safety is further defined as

the effective nursing of a person/family from another culture by a nurse who has undertaken a process of reflection on own cultural identity and recognises the impact of the nurse's culture on his or her own nursing practice. (Wepa, 2003, p. 340)

Brascoupe and Waters (2009) note that it is important to locate the concept of cultural safety within the context of cross cultural relationships, between Aboriginal service receivers and non-Aboriginal service deliverers, and to consider how the concept affects relationships, power structures, and trust.

“Cultural sensitivity” is awareness that harm is possible and must be avoided. Cultural safety can be created through the education of health care providers. We need to examine our own cultural realities and attitudes that we bring to the encounter. We must be open minded and flexible and not blame the victims of historical and social processes for their current situation. It is the consumers of the service who decide which providers are culturally safe to practice (Ramsden and Spoonley, 1994). Culturally sensitive care is broadly defined as service settings where women feel comfortable and respected (NAHO, 2006).

PAPANICOLAOU SCREENING PROGRAMS

Canada is at the forefront of reducing the incidence of cervical cancer through their comprehensive Papanicolaou (pap) screening programs. The Pap test, invented in the 1950s, screens for cervical dysplasia and its precursors. As a screening test, its success depends on repeated tests over the lifetime. Abnormal results require colposcopy for diagnosis. For Aboriginal women living in remote areas, the cost of this follow-up, including travel, accommodations, and childcare, can be prohibitive. Health Canada (2003, p. 3) reports that “many Aboriginal people live in small communities located in rural and remote areas of the country where access to health care services is limited.” It is recommended that women are screened every three years from the initiation of sexual intercourse to 69 years of age. Cases of progressive cancer result from false-negative findings, sensitivity of only 51%, or lack of screening (NAHO, 2006).

RISK FACTORS AND INCIDENCE

Risk factors for cervical cancer include a higher number of sexual partners, lower age at first intercourse, as well as the sexual behaviour of a woman's partner. Associated risk factors include smoking, a higher number of live births, deficient diets, HIV infection, and long term (more than 12 years) use of oral contraceptive pills [OCPs]. Risk factors increase a person's chances of developing a disease. Nicotine metabolites can be found in the cervical mucus of women who smoke, potentially supporting the theory that cigarette smoking has a direct carcinogenic action

on the cervix. Aboriginal women have higher rates of smoking than non-Aboriginal women (Duarte-Franco and Franco, 2003; Elias et al., 2011; NAHO, 2006), although there is no evidence based correlation between high rates of smoking by Aboriginal women and increased rates of cervical cancer.

An estimate of new cervical cancer cases, diagnosed in Canada in 2002, is 1,450 with 420 deaths. Women diagnosed with cervical cancer are on average 20 years younger than women diagnosed with other genital cancers (Duarte-Franco and Franco, 2003, NAHO, 2006). It is difficult to determine the rates of cervical cancer and screening in Aboriginal populations. Because the Canadian cancer registry does not collect information on ethnicity, data cannot be isolated to examine screening rates in the Aboriginal population. Reserves are excluded from national health surveys monitoring preventative health practices. A lack of valid numbers for screening rates for Aboriginal women may reduce the amount of funding allotted for specific communities or regions. Without sufficient funding, the needs of the community or region may not be properly addressed and there may be a lack of human resources available to administer culturally sensitive screening strategies.

Through manipulation of various Manitoba databases, Young et al. (2000) estimate that Aboriginal women have 1.8 to 3.6 times the rate of invasive cervical cancer, with a peak incidence between the ages of 20–34 years. Furthermore, the rates of Pap tests for Aboriginal women are lower with 43% of Aboriginal women having Paps in the previous three years versus 60% of non-Aboriginal women. Cervical cancer is considered a “modern” cancer in these populations as a result of rapid social and lifestyle changes. In the Northwest Territories the rate accounted for 35% of all cancers diagnosed, primarily affecting Aboriginal women. In Ontario, cancer of the cervix occurs 73% more often in Status Indian (SI) women than all other Ontario females (NAHO, 2006). Hislop et al. (1992) set out to determine the rate of cytology screening among 28 bands in British Columbia. They found that Native women participated 30% less than other women in British Columbia. In 1997, Aboriginal women had 6 times

the rate of cervical cancer compared with all other Canadian women (NAHO, 2006).

HISTORICAL FACTORS INFLUENCING BARRIERS TO CERVICAL CANCER SCREENING

Discourses regarding reproductive risks should include analyses of the historical, sociopolitical, and economic conditions that intersect and influence the lives of Aboriginal women (Browne and Smye, 2002). Colonial relationships are gendered and sexualized. Sexual violence is a tool of patriarchy, but also a tool of colonialism and racism. Aboriginal women are then victims of sexual violence. When a Native woman suffers abuse, this is not only an attack on her identity as a woman, but on her Native identity. The issues of colonialism, race, and gender oppression cannot be separated. With regards to Aboriginal women, sexual violence, and reproductive health, Native women have been threatened because they can produce the next generation of people who can resist oppression. In the 1970s it was revealed that 25% of Native women were being sterilized without their consent. Rates reached as high as 80% on some reservations. This practice continues today in the form of dangerous contraceptives such as Norplant and Depo-Provera. Smith (2003) asserts that as long as colonial governments engage in this social war against Native women's bodies, distrust towards reproductive health care systems and providers will continue. This distrust can prevent acceptance of cervical screening programs.

CERVICAL SCREENING BARRIERS FOR ABORIGINAL WOMEN

The health care system erects barriers through lengthy delays between screening and referral or diagnosis, high staff turnover, and difficulties securing appointments. Jurisdictional issues mean that Status Indians may have to navigate band, municipal, provincial, and federal levels of government to access health services. Others factors include geographical location, lack of awareness, shyness, discomfort, and distrust born out of historical abuses (NAHO, 2006). Aboriginal women have mentioned that they are not comfortable talking about Pap

smears, even among family and friends. Many have been screened in pregnancy but some have confused the test with testing for sexually transmitted diseases (STDs) while others thought it was necessary for oral contraceptives. Overall, they are embarrassed and uncomfortable, both psychologically and physically, particularly with male physicians (Waldram et al., 2007).

HEALTH CARE PROVIDERS

Health care providers need increased awareness of cultural concepts as well as information on other barriers to care. The shortage of primary health care providers may reduce consistency or continuity of care and a woman's preference for a female provider may be denied (NAHO, 2006). The isolation of some reserves and communities is often a factor in this situation. Aboriginal women need Aboriginal health care providers for an opportunity to share and transfer knowledge on an Indigenous-woman-to-Indigenous-woman basis. The Native Women's Association of Canada [NWAC] (2007) takes the position that Aboriginal women need to be encouraged to pursue midwifery or to specialize in obstetrics and gynecology as nurses, nurse practitioners, and physicians.

Native women may perceive interview questions as too personal and intrusive; they may distrust that the information given to providers will be kept confidential. Screening for disease is a preventative behaviour; this conflicts with only going to the doctor when one is ill. Some have complained that they have been treated badly by health care providers and that the service is fundamentally "discriminatory" (NAHO, 2006). Many Aboriginal women complain that health providers do not ensure their fully informed consent. Such consent requires full information, in plain language, about the potential and recommended treatments and medications as well as the possible risks and side-effects. Without this full, plain language information, a truly informed decision is not possible (NWAC, 2007). Further complicating these barriers are poverty, substandard housing, and unemployment which can take priority over preventative health care (NAHO, 2006).

Interview and focus groups with immigrant and Aboriginal women revealed similar reasons for non-

attendance at screenings, including lack of knowledge about the importance, staff turnover, embarrassment, discomfort, and male physicians. Through interviews with immigrant and Aboriginal women in northern Ontario, specifically Ojibwa and Oji-Cree, Steven et al. (2004) conclude that Native women may have a more intense sense of privacy than other women, resent having strangers touch them, and find examinations to be intrusive. The Native women stated that they felt that their privacy was violated and that they felt shy about having a physician touch them. In fact, 33% of the Native women refused to have an internal examination compared with 0–8% in other populations (Steven et al., 2004).

ADDRESSING CERVICAL SCREENING BARRIERS FOR ABORIGINAL WOMEN: STRATEGIES

Cultural beliefs, attitudes, and practices of Aboriginal women are an important part of planning strategies to reduce barriers to cervical screening. Issues of modesty can be misunderstood or ignored by physicians. Native women are often less direct in their communication requiring more time and more prompting in the medical encounter. The Northern Plains tribes, specifically the Apsaalooke (Crow) of southeastern Montana, have the highest rates of mortality from cervical cancer in North America and very low rates of screening. Cervical health education of Apsaalooke women increased their understanding of cervical health through their "Messengers of Health" program. These Native women acted as liaisons between the women and health care professionals and provided childcare and transportation (NAHO, 2006).

TALKING CIRCLES

The use of talking circles has been examined as a way for women to share their fears, concerns, or needs. Talking circles are a traditional pattern of intragroup communication, specific to Native communities, to share information, offer support and solve problems. Becker et al. (2006) conducted research to understand the cultural meanings of cancer as well as the experiential views of breast and cervical cancer

screening among female members of the Northern Plains tribes living in western South Dakota. The members of the research team were Native as well as the analysis team (transcriptionist, three coders, and three categorizers) to enhance the rigour of the qualitative analysis. The study involved an exploratory design using talking circles for the focus group methodology. The study design included story telling which related to health behaviour in general. A respected female spiritual leader who was an expert at intragroup communication and traditional symbolism was chosen to lead the groups. The circles brought forth conversations and stories about how participants think and feel about cancer as well as the opportunity for the concept of spirit to be connected to cancer. In recognition of the talking circle's cultural significance, each session opened with smudging with sage "so that the spirits were ready." The circles took place in a private home because participants felt more comfortable revealing their personal views in this setting (Becker et al., 2006).

The talking circles exposed health care beliefs and attendant behaviours that were barriers to screening participation. The following are some of the themes that emerged:

Native languages have no name for cancer. Evil spirits and elements beyond one's control were identified as etiological causes of cancer. The word is threatening, damaging, and final. It can impoverish due to the cost of treatments, drugs, and supportive services.

Life with Mother Earth is only part of the continuum. Cancer is beyond one's control and you eventually die of something. Live in the present. Do not dwell on illness or negative events.

Nonownership of the cancer disease. Early detection or preventative measures are not understood or valued.

Others take priority. If women had cancer, they would have a hard time deciding who to look after; themselves or their family. Respect for the needs of others and care for the extended family is a strong factor distracting women from self-care.

Pap smear means sexuality and trauma. When women talked about incest or rape they included experiences about Pap tests. Shame and humiliation

are associated with Pap tests. Testing by male providers is a problem as well as going to a new provider each time.

Lack of trust. Within the health care system, scheduling, tests, and rules lack flexibility.

Significant others play an important role. Women were motivated through encouragement by family, friends, Elders, and health providers (Becker et al., 2006).

Through talking circles, researchers were able to explore the interrelationships among the women's religion, traditions, the health care system, and the family, providing a unique holistic perspective for conceptualizing the cancer screening experience among Northern Plains Tribes American Indian women (Becker et al., 2006).

Talking circles were also used in a study conducted among Yamaka women, Wa'Shat Longhouse, Washington State to gain a greater understanding of the importance of religion to the design of a culturally appropriate cervical cancer prevention program. Findings suggest that program goals need to be holistic and wellness oriented, teaching methods need to include circular symbols, and intervention strategies need to be linked to the natural communication patterns and involve Elders. Storytelling, talking circles, and role models are important teaching methods. Education needs to address issues across the lifespan, should include positive messages about cancer such as how to take care of themselves, and contain information for the entire community. Women's wellness programs need to be framed to emphasize the importance of self-care for the greater community good and not for the self alone. Women are looking for a wellness approach. According to Longhouse beliefs, disease is the result of personal imbalance. Preventative strategies restore balance. Health promotion should encompass healthy lifestyles, diet, exercise, healthy relationships, respect, and protection of the land. Provider education is also required to facilitate communication with the women, traditional healers, and Elders. The talking circle is not a place to distribute prevention information but rather opens up important avenues for future health promotion communication (Strickland et al., 1999).

STRATEGY FOR CHANGE: DESIGNING EFFECTIVE PROGRAMS

The challenge is to provide holistic, community-based health care within a Western-dominated health system. According to the report *Sacred Space of Womanhood*, some traditional practices and ceremonies have been renewed or even reinvented for contemporary life (National Collaborating Centre for Aboriginal Health, 2012, p. 12). Many Aboriginal guidelines stress the importance of reciprocity, respect, equality, survival and protection, responsibility, spirit and integrity.

Women often seek Native healers for female problems and issues surrounding pregnancy and childbirth. A holistic approach is a return to traditional ways, eating traditional foods, exercise, good relations with others, drinking water, learning from nature and protecting her gifts (Strickland et al., 1999). Native women diagnosed with cancer may seek treatment from traditional specialists either in conjunction with or as a substitute for Western medicine. Women have reported that prayer, healing ceremonies, the use of roots and herbs, counsel from a medicine man, and touch/manipulation are common practices, particularly among Elders. Some programs have a traditional healer on staff and all clinicians should accept traditional approaches as complementary to standard medical treatment (Lantz et al., 2003).

It may be respectful to first meet with Elders, grandmothers, aunts, and mothers who are recognized as the cultural guardians (Kelly, 2006). The inclusion of Aboriginal women and the wisdom they hold in the planning, delivery, implementation, and evaluation of cervical cancer screening initiative ensures their voices are heard.

... the resiliency of Aboriginal peoples is evident in the vital role of women and mothers in Aboriginal societies. Strength to move forward as healthy individuals, families and communities is inextricably linked to Aboriginal women, mothers, grandmothers and aunts as the bearers of future generations. (National Collaborating Centre for Aboriginal Health, 2012, p. 6)

Also, authentic consultation with Aboriginal women about their own sexual health at the planning, implementation, and evaluation stage of cancer screening campaigns and/or programs has the potential to increase participation.

The service delivery model must fit the population being served and the health care system within which the program operates. There is no "one-size-fits-all" approach since each community is organically unique and cannot be duplicated exactly in other settings. What is offered in this paper are evidence based suggestions that can be adapted to any area with authentic consultation coming from the Aboriginal community or population on what they believe will work. Strickland et al. (1999) posit that "Yamaka women's spiritual beliefs involve not wanting to give up any part of the body so refraining from describing the removing of cervical cells is important." This is not recommended as it may be construed as withholding important information from the Aboriginal woman receiving services, impeding the patient-health care provider relationship by creating distrust. Petersen et al. (2002) write that other authors have reported a range of views from the belief that it is disrespectful to the Creator to take away even a few of the body's cells for a Pap test to conceiving of time as a river, not made up of discreet units such as specified appointment times. This is an opportune time to build a stronger relationship with Aboriginal women by explaining the process of testing cervical cells and how their samples are disposed of. It is also important to secure the support and cooperation of providers and staff with appointment scheduling, private space for screening, and education and data gathering for tracking and follow-up (Lantz et al., 2003).

Four themes emerged from discussion with Aboriginal women in northern Ontario. They suggest the use of multimedia sources to inform women of screening programs, including key informants and social networks. They recommended the use of videos rather than booklets, airing special programs on local cable television, and suggested putting information on grocery bags, coupons, and refrigerator magnets. Finally they suggested that home visits from either Native nurses or culturally sensitive

health care workers would be effective in providing educational sessions individually or in groups. Educating women about cervical cancer screening should occur in high school or earlier to allay fears and foster positive health behaviours. Participants stated clearly that scare tactics do not work. Women wish to be reminded when they are due for screening. Methods suggested included postcards and telephone reminders, record forms, reminder stickers, calendars, and refrigerator magnets. Native women have suggested that care providers describe the procedure step-by-step along with the rationale. Female examiners are preferable as well as accessible and comfortable environments and performing the procedure to minimize discomfort (Stevens et al., 2004).

Native WEB (Women Enjoying the Benefit) is a training program for nurses employed by the Indian Health Service in the United States. It teaches nurses how to administer and maintain high-quality screening programs and cervical cancer screening techniques. Interviews with 60 nurses representing 35 Native health clinics, were conducted. They reported that clinics appear to favour cervical screening promotion among their existing client base over community members. A strategy to expand their influence would be to offer screening to all women who visit the clinic for other reasons. Native women prefer that Native nurses conduct their Paps but are most insistent that the provider is female (Petersen et al., 2002). In a study conducted with the Lumbee tribe in North Carolina, a trained lay health educator visited women in their homes, providing verbal, print, and video information. They concluded that the program resulted in greater knowledge about cervical cancer prevention and higher proportions of Lumbee women obtaining Pap smears in the following year. Acknowledging the success was tempered by evidence that education, income, ethnic identification, and access to health care were found to be factors that influenced the success of the program and those at highest risk were the least likely to respond (Dignan et al., 1998).

A multisite case study was conducted using a participatory research process to describe how five tribal programs implemented cervical screening programs with American Indian and Alaska Native

women. The following is a summary of the strategies implemented in all tribal programs. It is important to use a model that best fits the population and the existing health care resources. Identify a “champion” or program supporter in each clinic setting and show how the programs complement rather than compete with existing programs. The “champion” is an on-site expert on the program as well as a cheerleader. It is essential that not just providers but also administrative and support staff understand the program and how important their support is to its success. Use female providers, preferably Natives, and fill as many staff positions as possible with Native people. Allow ample time for appointments and use a gentle communication style. Be able to communicate in the Native languages or have translators available. Provide culturally appropriate health education materials. Provide case management to all women with abnormal results and provide transportation (Lantz et al., 2003).

The Native Women’s Association of Canada [NWAC] make the following recommendations for Aboriginal women’s reproductive health care. They ask that providers understand the importance of Aboriginal women’s roles in teaching young women about the physical aspects of womanhood and holding related ceremonies. They ask that researchers conduct studies specific to First Nations, Inuit, and Métis women, restoring their roles in individual, family, and community health. This would include research into more effectively combining traditional approaches to reproductive health care with other health services. Research should also cover the entire spectrum of lifetime reproductive health and combine traditional and Western medical approaches. Encouragement, increased financial support, and more opportunities must be made available to Aboriginal women to pursue careers in women’s health. Encouraging dialogue between Aboriginal and non-Aboriginal care providers will promote more culturally sensitive care. Finally, immediate, substantial improvements are needed to the social, economic, and political conditions in which Aboriginal women and their families reside (NWAC, 2007).

Reath and Carey (2008) completed a research project wherein Aboriginal and Torres Strait Islander

women in Australia had access to a female Indigenous worker and a female general practitioner (GP). These project personnel consulted with local organizations and stakeholders to develop and implement a plan to improve GP early detection of breast and cervical cancer in these women. Flexible local agreements focused on four key areas identified in the literature:

1. links between services to improve coordination and access;
2. GP continuing professional development (CPD) including cultural awareness and Indigenous women’s health;
3. improvements to recall and reminder systems;
4. health promotion.

Results from this research project were improvement in service communication and cooperation, strengthening of relationships between GPs and local Indigenous health centres, changes in awareness and knowledge of culture and Indigenous women’s health, and increased number of women attending cervical cancer screening tests. Reath and Carey (2008) conclude that involving Indigenous health workers resulted in an exchange of insights between Indigenous and mainstream health services.

In a pilot study conducted by Zehb et al. (2011) 49 Fort William First Nation women, aged 25–59, were recruited who provided a vaginal self-sample, and answered a questionnaire. Self-sampling has been reported to increase screening compliance for women who have never or not regularly been screened. The project nurse provided each participant with a sterile, plain polyester Dacron swab 15 and transportation tube. For confidentiality, HPV test results were blinded to the project nurse, which ensured that members of the research team did not have access to the names of the participants or to individual test results. The results of the questionnaire that was part of the study revealed 87.2% of the women were willing to participate in self-sampling in the future, 67% prefer self-sampling to HCP [Health Care Provider] sampling, 77.1% found self-sampling easy and 61.7% found it comfortable (Zehb et al., 2011, p. 4). They further report that a larger survey to be conducted in other northern Superior communities in northwest Ontario will determine

whether this approach could become a viable screening strategy for First Nation women.

The Society of Obstetricians and Gynaecologists of Canada (SOGC) in their policy statement entitled *A Guide for Health Professionals Working with Aboriginal People*, provide Canadian Health professionals information and recommendations regarding Aboriginal health. The recommendations are grouped according to four themes: sociocultural context, health concerns, cross-cultural understanding, and Aboriginal health resources. Their recommendations echo the strategies previously outlined for reducing barriers to access and creating welcoming environments (Smylie, 2000).

The program designs that were discussed are summarized in the table below. This was completed so readers are able to look at the nations, reasons for supportive involvement, types of support/completed research, and the results or outcomes of the support/research in an easy to read format.

DESIGNING A CERVICAL CANCER SCREENING STRATEGY/PROGRAM WITH ABORIGINAL WOMEN

Authentic participation and support from the Aboriginal community or population is required for a successful strategy/program. Reath and Carey (2008) are of the opinion that there is a need to move beyond documenting Indigenous health problems to finding solutions. Therefore, cervical cancer screening strategies should be refocused on seeking and maintaining *Mino-Bimaadizwin*.

For an Anishnaabe [Aboriginal] person, *Mino-Bimaadizwin* is a way of life, 'the good life' and something that one works toward on one's life-long journey. (Goudreau, 2006, p. 120)

The successful design of a strategy/program for maintaining *Mino-Bimaadizwin*, requires the following.

PLANNING

1. Is there proper representation of Aboriginal people in the planning circle? Of Aboriginal women who will be the consumers of said service? Do they have an authentic role as partners or leaders within the circle?

2. Is there a traditional Elder, medicine person, Métis Senator involved in your planning circle in an advisory capacity? As a contributing member?
3. Is there already an informal knowledge transfer model in the Aboriginal community that can be adapted to this strategy/program? Who will you ask to see if there is such a model? How do you utilize the model respectfully without appropriating it?
4. Will there be an exchange between your agency/yourself as a health care practitioner to ensure things are done in "a good way"? e.g. offering of tobacco, written agreement.

IMPLEMENTATION

1. Will there be literature available to the Aboriginal women that they will identify with? In their language? With familiar graphics?
2. Where will the services take place? In their home? Local Native organization? Hospital? If not in their home, will the area be culturally friendly? E.g., artwork from their nation, traditional medicines available, etc.
3. Will you work with a traditional healer? Translator? Auntie? Grandmother?
4. How much time will you allot for each appointment? Will there be resources available to accommodate drop-ins? Counselling services for positive testing? Referral services?
5. Can funding be guaranteed to allow continuity of care and trust building?

EVALUATION

1. How will you ensure your agency/yourself is reaching the target audience? in a good way?
2. How often will you complete evaluations?
3. Will you have the resources available to address the increased needs of Aboriginal women, if requested? If not, are there any solutions that will not exhaust your finite resources?

Another area to consider is the importance of the individual, family, community, and nation to many Aboriginal peoples. If her life is affected in any way (negative or positive) this affects her family

Table 1. Summary of Program Designs

<i>Nation</i>	<i>Reason for Supportive Involvement</i>	<i>Type of Support</i>	<i>Results of Support/Research</i>
Apsaalooke women from the Northern Plains tribes of Southeastern Montana (NAHO, 2006)	Highest rates of mortality from cervical cancer in North America and very low rates of screening	"Messengers of Health" program — These native women acted as liaisons between the women and health care professionals and provided childcare and transportation. (NAHO, 2006)	Cervical health education Increased their understanding of cervical health
Northern Plains tribes living in Western South Dakota (research) (Becker et al., 2006)	Research conducted by Native researchers to understand the cultural meanings of cancer as well as the experiential views of breast and cervical cancer screening among female members	Talking Circles Story telling Female spiritual leader Smudging Home based setting	Native languages have no name for cancer Life with Mother Earth has only part of the continuum Nonownership of the cancer disease Others take priority Pap smear means sexuality and trauma Lack of trust Significant others play an important role
Yamaka women, Wa'Shat Longhouse in Washington State (research) (Strickland et al., 1999)	Research conducted to gain a greater understanding of the importance of religion to the design of culturally appropriate cervical cancer prevention program		Program goals need to be holistic and wellness oriented Return to traditional ways, eating traditional foods, exercise, good relations with others, drinking water, learning from nature and protecting her gifts Intervention strategies need to be linked to the natural communication patterns and involve Elders Storytelling, talking circles and role models are important teaching methods Suggest the use of multimedia sources to inform women of screening programs Home visits from either Native nurses or culturally sensitive health care workers for educational sessions individually or in groups Educating women about cervical cancer screening should occur in high school or earlier to allay fears and foster positive health behaviours Describe the procedure step-by-step along with the rationale Female examiners are preferable, along with accessible and comfortable environments and performing the procedure to minimize discomfort
Aboriginal women in northern Ontario (Steven et al., 2004)			
Native WEB (Women Enjoying the Benefit), training program for nurses employed by the Indian Health Services (research) (Petersen et al., 2002)		Interviews with 60 nurses, representing 35 Native health clinics, were conducted	Clinics appear to favour cervical screening promotion among their existing client base over community members Strategy to expand their influence would be to offer screening to all women who visit the clinic for other reason Native women prefer that Native nurses conduct their Paps but are most insistent that the provider is female
Lumbee tribe in North Carolina (research) (Dignan et al., 1998)		Trained lay health educator visited women in their homes, providing verbal, print and video information	Resulted in greater knowledge about cervical cancer prevention Higher proportions of Lumbee women obtaining Pap smears in the following year Evidence that education, income, ethnic identification, and access to health care were factors that influenced the success of the program Those at highest risk were the least likely to respond Use a model that best fits the population Identify a "champion" or program supporter in each clinic setting
Five (5) tribal programs for American Indian and Alaska Native women (research) (Lantz et al., 2003)		Describe how five (5) tribal programs implemented cervical screening programs	Use female providers, preferably Natives, and fill as many staff positions with Native people Allow ample time for appointments Use a gentle communication style Be able to communicate in the Native languages or have translators available Provide culturally appropriate health education materials Provide case management to all women with abnormal results and provide transportation

Nation	Reason for Supportive Involvement	Type of Support	Results of Support/Research
Native Women's Association of Canada (NWAC) recommendations for Aboriginal women's reproductive health care (NWAC, 2007)			Providers understand the importance of Aboriginal women's roles in teaching young women about the physical aspects of women hood and holding related ceremonies Ask that researchers conduct studies specific to First Nations, Inuit, and Métis women, restoring their roles in individual, family and community health Encouragement, increased financial support and more opportunities must be made available to Aboriginal women to pursue careers in women's health Dialogue between Aboriginal and non-Aboriginal care providers needs to be encouraged to promote more culturally sensitive care
Aboriginal and Torres Strait Islander women, Australia (Reath and Carey, 2008)	Aimed at implementing and evaluating strategies to improve general practitioner (GP) early detection of breast and cervical cancer	In three sites a female Indigenous worker and female GP developed and implemented local plans to improve service coordination and access, GP knowledge, recall systems, and health promotion Launch of an alternative approach to (Pap)anicolaou testing in a clinic namely, vaginal self-sampling followed by human papillomavirus (HPV) diagnostics.	Collaboration between service providers, community participation in planning and delivery An Indigenous health worker raising awareness in both the women and general practitioners (GP) Female GP providing a holistic service an important factor Increased cervical screening was documented in one site
Fort William First Nation, Ojibwe in Northwest Ontario (Zehb et al., 2011)	To raise screening participation in this underserved population		Self sampling and HPV testing was well received and self-sample quality was excellent The majority of participants (87.2%) were amenable to future HPV screening by self-sampling The preferred way to learn about sexual health remained through interaction with healthcare professionals

and in turn, her community and nation. Please keep this in mind in your helping relationships with Aboriginal women.

Also there are many Aboriginal peoples who are at various stages of assimilation: reuniting with their traditional practices, in the process of healing from historical hurts, and also those who have not yet been exposed to their traditions and history. Given the explicit colonialism in the early years of Canada, this outcome is common and efforts can be tailored to these unique Aboriginal women who have their own special gifts to share.

As mentioned earlier in this paper, there can be no set program or design for your intended community, but there can be a flexible framework that encourages movement and growth. This framework of questions can gently guide you and the Aboriginal community or population you are in partnership with in a direction that promotes *Mino-Bimaadizwin*.

CONCLUSION

Community members, leaders, and health care workers must all be involved in efforts to increase the effectiveness of cervical screening programs among Aboriginal women. Midwives are ideal-

ly situated within many communities to provide sensitive reproductive health care. Midwives need to educate themselves concerning the best possible care, including an appreciation for the historical background informing the modern socioeconomic conditions. This requires that midwives recognize and respond to key areas of morbidity, free from stereotypes. The support and true participation of Aboriginal communities should be sought and educational outreach undertaken to improve the uptake of services. Thought needs to be given to the caring environment as well as the structure of care in order to encourage continued access. There are many opportunities to incorporate traditional Native communication and healing strategies in a reproductive midwifery health service that is truly responsive and sensitive to the needs of Aboriginal women, their families and communities.

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