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**Choice, Morality and Vulnerability: Young Women's Discourses of Cervical Screening**

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### Abstract

Cervical screening is a health surveillance tool used to prevent cervical cancer. In New Zealand, research into cervical screening has largely focused on barriers to participation. This type of research implicitly assumes that cervical screening is a desirable health behaviour for women to engage in, and does not explore how social and political factors are implicated in cervical screening behaviour. This research sought to explore women's understandings and experiences of cervical screening. Ten women aged 20 to 30 were interviewed, their responses recorded and transcribed, and an interpretive analysis conducted. From the analysis, three broad webs of discourse surrounding cervical screening – choice, morality and vulnerability – were identified and discussed. Each web of discourse was used to construct cervical screening in different ways. For choice, participants constructed cervical screening as an autonomous choice, routine, or an obligation. Morality was drawn upon for its role in cervical screening around ideas of individual and social responsibility, and sexual activity. Finally, vulnerability was explored through the fear of getting cervical cancer, the vulnerability experienced as part of screening, and the protection it was seen to offer. Choice, morality and vulnerability worked together to limit the available ways of experiencing and acting in relation to cervical screening, constructing compliance as the only option for women. Those who do not comply are positioned as problematic, irresponsible and immoral by women, their friends and families, and health professionals. This research highlighted the ways in which discourses produce realities which create and maintain power imbalances which govern and control women's bodies. Rather than viewing cervical screening as a desirable yet morally neutral act which all women ought to participate in, it is a site where women may choose to comply or resist dominant discourses which exert power over women's bodies.

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## Introduction

### Background

Cervical screening is a tool which is used for prevention of cervical cancer. Cervical cancer, or cancer of the cervix, occurs when abnormal cell changes in the cervix become cancerous, and may then spread to other areas of the body, such as the uterus, vagina and bladder (American Cancer Society, 2016; Ministry of Health, 2014a). The abnormal cell changes are considered to be caused largely by persistent infection with human papillomavirus (HPV), a virus which is transmitted through skin-to-skin contact, particularly sexual contact, and only a small number of abnormal cell changes will develop into cancer (Ministry of Health, 2014a). There are two high-risk types of HPV, 16 and 18, which are thought to be responsible for 70% of cases of cervical cancer (Gillison, Chaturvedi, & Lowy, 2008). There are a number of factors other than HPV which increase the risk of a woman developing cervical cancer, including a family history of cervical cancer, smoking, and higher numbers of sexual partners (Ministry of Health, 2014a).

In this section, I will be exploring cervical cancer's impact on women's health, cervical screening's role in prevention, and cervical cancer and screening in a New Zealand context. I will examine and critique the existing research on cervical screening, consider issues with current approaches to cervical screening, and make my case for a more critical approach to cervical screening, before stating the aims of the research project.

Cervical cancer, like all cancers, can have a devastating impact on those who develop it and their families (Edwards & Clarke, 2004). Cervical cancer may have its own unique complications which impact on both quality of life and intimate relationships. Women who have cervical cancer might experience: sexual dysfunction; nerve damage leading to reduced sexual sensitivity; bowel and bladder issues; vaginal changes including scarring, pain during intercourse and dryness; as well as issues with existing and new intimate relationships and fertility problems (Hunter, 2014).

Among women, cervical cancer is the second most common cancer worldwide (Cervical Cancer Audit, 2004). The incidence and mortality rates for cervical cancer vary a great deal worldwide, with some developing countries having incidence rates of around 42.7 per 100,000 women (World Health Organization, n.d.-b), while other countries such as New

Zealand have incidence rates of 7.1 per 100,000 women (Cervical Cancer Audit, 2004). There is also a large variation in cervical cancer mortality rates, with a worldwide average of 6.8 deaths per 100,000, but as high as 27.6 in Eastern Africa, and as low as 1.5 in New Zealand (World Health Organization, n.d.-b).

The variation in cervical cancer globally has been attributed by government reports at least in part to the presence or absence of organised cervical screening programmes (Cervical Cancer Audit, 2004). Cervical screening increases the likelihood of abnormal cell changes which could develop into cervical cancer being detected early, before cervical cancer develops, or while cervical cancer is in an earlier stage and more treatable (National Screening Unit, 2014b). Official reports estimate that regular cervical screening could prevent up to 90% of the most common type of cervical cancer, squamous cell, which is implicated in 80% of cases (Dolinski & Hill-Kayser, 2015; National Screening Unit, 2014b). In countries with organised screening programmes, recommendations around screening age, interval and method of testing differ. Women are invited to start cervical screening at age 20 in New Zealand, 21 in the United States, 23 in Sweden, and 25 in the United Kingdom, and continue screening until aged 70 in New Zealand, 65 in the United States, 60 in Sweden, and 64 in the United Kingdom (Centers for Disease Control and Prevention, n.d.; Dillner, 2000; National Screening Unit, 2014b; Public Health England, 2015). How often women are screened can depend on their age and which country they are in (Centers for Disease Control and Prevention, n.d.; Public Health England, 2015). Different countries use different tests in cervical screening, which may be liquid-based cytology, HPV testing, or both (National Screening Unit, 2014b; Public Health England, 2015). Across different cultures and time periods, what is seen to be the correct or right way of preventing cervical cancer varies.

Cervical screening, as well as its benefits in reducing cervical cancer incidence and mortality (Cervical Cancer Audit, 2004), has some risks of harm associated. The World Health Organisation (n.d.-b) outlines guidelines that a screening programme should meet, which include detecting as many true positives as possible, and as few false positives or false negatives as possible. Because cervical screening detects and treats abnormal cell changes, of which only a small number would have ever developed into cancer (Ministry of Health, 2014a), cervical screening means that some women will be treated or monitored



unnecessarily. False positives, where women are told they have abnormal cell changes which could lead to cancer when they do not can create anxiety and distress, and there are medical risks of unnecessarily treating abnormal cell changes, which can cause trauma to the cervix and may increase the risk of premature delivery of pregnancies in the future (Sasieni, Castanon, & Cuzick, 2009).

Every year in New Zealand, around 160 women develop cervical cancer, one third of whom go on to die as a result (Ministry of Health, 2014a). The number of deaths from cervical cancer has declined since the establishment of the National Cervical Screening Programme, New Zealand's organised cervical screening service, to approximately half of the rate prior to the introduction of the programme (Cervical Cancer Audit, 2004). There are, however, significant disparities in relation to cervical cancer in New Zealand. The incidence of cervical cancer is twice as high for Māori women as non-Māori, and the mortality rate for Māori women is four times that of non-Māori (Cervical Cancer Audit, 2004). The reasons for these disparities have been debated, with some arguing it may be linked to differing standards of care, such as Māori women facing longer delays for investigation of abnormal results (Cervical Cancer Audit, 2004), whilst others attribute it to disparities in cervical screening uptake (Brewer, Pearce, Jeffreys, White, & Ellison-Loschmann, 2009).

In New Zealand, the National Screening Unit (2014a) recommends that women should undergo a cervical smear test every three years from the age of 20 to 69 if they have ever been sexually active, although there will be changes to screening age and interval as HPV testing is introduced in 2018 (National Screening Unit, 2016). 77 percent of New Zealand women are screened regularly within these guidelines, but this is lower for Māori women at 64 percent, Pasifika women at 74 percent and Asian women at 64 percent (Ministry of Health, 2016). The National Screening Unit (2014a) reports that the New Zealand cervical screening programme is one of the best in the world because of its role in reducing cervical cancer mortality. But these reductions have not been experienced equally, and the clear disparities in cervical cancer incidence, mortality and screening, have continued (National Cervical Screening Programme, 2005).

The history of New Zealand's cervical screening programme is not without controversy. The establishment of the programme itself arose after the Cartwright Inquiry in 1987-88, which investigated a study now known as the 'unfortunate experiment' at National Women's

Hospital in Auckland, where female patients were unknowingly part of a study which left abnormal cell changes untreated, resulting in many of the women developing cervical cancer and some dying (Coney, 1988). The Inquiry led to the National Cervical Screening Programme being implemented, and the development of a code of patients' rights to acknowledge the importance of informed consent (Women's Health Action, n.d.-a). In the years following, further issues with the delivery of cervical screening emerged after it became public that a laboratory in Gisborne had misread hundreds of screening results, highlighting a lack of quality control among cervical screening laboratories, and health professionals' resistance to and efforts to prevent having issues made public, which resulted in the Gisborne Inquiry (Women's Health Action, n.d.-b).

Currently, the cervical screening programme in New Zealand is subject to monitoring and evaluation by the National Screening Unit, the Ministry of Health and independent groups to ensure standards (Ministry of Health, 2014b), but there are continuing issues with the organisation of the programme. There is a distinct focus on compliance over informed decision making, with measures of the programme's success heavily relying on achieving high rates of screening uptake, health targets which incentivises health professionals to strongly encourage screening, and an opt-out rather than opt-in screening register meaning women are automatically recalled for cervical screening (Ministry of Health, 2016; National Screening Unit, 2014a; National Screening Unit, 2014c). The consequence of this approach to the cervical screening programme is that, while cervical screening may well have health benefits, women are not able to make an autonomous choice about participating. There is a focus on individuals' behaviour, and how to encourage participation in screening, which means that those who do not wish to participate in screening can be seen as problematic. At the same time, this focus on the individual ignores the social context that surrounds health and behaviour. Mielewczyk and Willig (2007) have called for recognition of the role that social context plays in health behaviour, saying that the two are inextricably linked, so in looking at improving people' health, there is a need to consider how they may be constrained by factors such as gender, class, sexuality, culture and ability.

Informed consent has been an issue in the context of the New Zealand health system for many years, with reports that some doctors in recent history believe patients have a limited capacity for understanding health information, and that it is unrealistic and unhelpful to

provide them with all the information (Strid, 1993). Informed consent needs to be based on consumers being given information on alternative options, potential risks or side effects of a treatment, and the potential outcomes of non-treatment (Medical Council of New Zealand, 2011; Strid, 1993). Cervical screening policies designed to promote compliance, which emphasise the benefits of screening while de-emphasising risks, fail to acknowledge women's autonomy and promote informed decision making, and cannot be considered ethical (Auckland Women's Health Council, 2011; Foster & Anderson, 1998; Raffle, 2001). Informed consent and decision making underpin the legislation which governs health services in New Zealand, with the HDC Code of Health and Disability Services Consumers' Rights Regulation 1996 including the right for health consumers to make fully informed decisions about their health, and the Medical Council of New Zealand stipulating that doctors are obliged to "inform the patient about the potential risks and benefits of the options available and support the patient to make an informed choice" (2011, p.1). However, when there is a strong drive to promote compliance, informed decision making is likely to be undermined.

It is also important to explore women's experiences and understandings around HPV, the virus that leads to abnormal cell changes and cervical cancer. The primary cervical screening test in New Zealand will change from liquid-based cytology to HPV testing in 2018 (National Screening Unit, 2016), which is likely to highlight HPV's role in cervical cancer more so than has been done previously. Previous health promotion and communication efforts have avoided emphasising HPV's role in cervical cancer and its transference through sexual contact (Parker, 2010; National Cervical Screening Programme, 2012; National Cervical Screening Programme, 2013; National Cervical Screening Programme, 2014). Under the new pathway, rather than an abnormal result meaning abnormal cell changes on the cervix, an abnormal result will mean testing positive for HPV infection. As HPV will become a more salient aspect of cervical screening, it is important that research considers the role of HPV in women's understandings and experiences of cervical screening. HPV's link to sexual behaviour and the consequences this may have for those for whom sexual behaviour is taboo, for those who are not sexually active or for those who do not consider themselves at risk, may impact women's experiences of and understandings of cervical screening and

cancer, and may influence their likelihood to participate, as well as influence the impact that an abnormal result has on them.

Cervical screening and cancer in a New Zealand context is worth exploring given the continued disparities in incidence, mortality and screening; its history fraught with ethical issues; and the focus on compliance over informed consent in New Zealand's cervical screening programme. The disparities have continued despite governmental efforts to increase participation in cervical screening, with health promotion efforts and publications targeted to groups who have lower uptake of cervical screening such as Māori women (e.g., National Cervical Screening Programme, 2013). These initiatives have focused on individual behaviour change, making women responsible for their own health and sickness, and ignored contextual factors such as colonisation and marginalisation which may impact on experience of and engagement with health services such as cervical screening, as well as on health itself.

### **Previous Research**

Some of the research into cervical screening has focused on predictors of screening, most frequently using responses from national health surveys and conducting statistical analyses to identify predictors of cervical screening behaviour, such as ethnicity, age, marital status, socioeconomic status, education, and health factors such as smoking status (Lin, 2008; Selvin & Brett, 2003). In New Zealand, research has identified several predictors of lower screening uptake, which include being Māori, being older, and a shorter length of time living in New Zealand (Gao, 2008; Sykes, Sadler, & Priest, 2008).

Other research has centred on barriers to screening, to try to identify the reasons why women may not participate in cervical screening. These barriers are reported to span many areas, and vary for different groups of women. A lack of suitable, free services with skilled practitioners was identified as a barrier by Pacific health and community workers in New Zealand, with cost and being able to take time off work or arrange childcare for screening being important factors influencing screening behaviour, along with health professionals who had an understanding of Pacific culture (Foliaki & Matheson, 2015). A lack of knowledge on the purpose of screening and embarrassment about screening were reported

to be barriers for Pacific, Māori and Asian women in New Zealand (Jameson, Sligo, & Comrie, 1999; Lovell, Kearns, & Friesen, 2007), while for some Māori women, a general mistrust for the health system was considered a barrier to cervical screening, linked to the Western medical system being built on a foundation of colonisation (Lovell, Kearns, & Friesen, 2007).

In situations where English is not someone's first language, not having access to a healthcare interpreter has been reported to act as a barrier. This may be due to not being aware of the availability of an interpreter (Lovell, Kearns, & Friesen, 2007), a suitable interpreter not being available (Peters, 2012), or a belief that it is inappropriate to have an interpreter present (Buetow, Janes, Steed, Ihimaera, & Raina Elley, 2007).

Barriers to cervical screening may differ for women from specific groups beyond cultural differences. For women with disabilities, a lack of accessible services have been described as a barrier to cervical screening, such as needing physical assistance if accessible equipment is unavailable which reduces independence (Peters, 2012). For many groups of women such as those living in rural or isolated areas, those with disabilities, and those living in poverty, travelling to have a smear may be difficult if they have to travel a long distance or if there is a lack of public transport options (Brewer, Pearce, Jeffreys, White, & Ellison-Loschmann, 2009; Lovell, Kearns, & Friesen, 2007; Peters, 2012).

Buetow, Janes, Steed, Ihimaera, and Elley (2007) reported on reasons women did not return for cervical screening. They reflected that an individual health professional or screening experience could influence screening behaviour, such as having a male smear-taker, feeling unclean, or not being asked for consent before the smear was taken. For the women interviewed by Buetow et al., cervical screening affected their sense of aloneness with their body, invading their privacy, creating feelings of being exposed, and producing a sense of isolation and a loss of control over their body. This research highlights the ways in which women may feel extremely vulnerable when undergoing cervical screening.

The role that sexuality plays in women's cervical screening behaviour was a common theme in several studies into barriers to cervical screening. In New Zealand, women who were interviewed to identify sociocultural barriers to screening talked about screening being unacceptable because it involved a smear-taker accessing an area that was used for sexual

intimacy, for their partners only (Lovell, Kearns, & Friesen, 2007). Similarly, research which has looked into barriers to screening for Pasifika women emphasised that the topic of sexuality made discussions about cervical screening difficult (Foliaki & Matheson, 2015; Jameson, Sligo, & Comrie, 1999). When considering an abnormal screening result, younger women in particular experienced judgement around the perceived link between sexual activity and cervical screening, and women perceived a link between cervical screening and sexually transmitted diseases, and there was shame associated with this (Jameson, Sligo, & Comrie, 1999).

Researchers have also reported that fear of or past experiences of sexual abuse can act as a barrier to cervical screening. Women who had experienced sexual abuse in the past expressed a fear around undergoing a smear and the vulnerability involved in doing so, particularly women with disabilities (Peters, 2012). Women who had not experienced abuse also discussed fear about abuse within a broader mistrust of the health system (Lovell, Kearns, & Friesen, 2007). The link between cervical screening and sexuality, and the vulnerability that this creates, may make participation difficult for women with concerns about or experiences of abuse.

Mckie (1995) reported on women's talk in focus groups, where participants discussed cervical screening in terms of their male partners' perspectives, who viewed it as having the potential to be a sexual event. This sexual dimension of cervical screening could make participating in cervical screening difficult for some women, particularly those in relationships where a male exerts control over a female partner, or those from cultures where there is a gender hierarchy.

HPV is an important aspect to consider in relation to cervical screening and cancer, being implicated in the biological mechanism that leads to most cervical cancers (The New Zealand HPV Project, n.d). While HPV causes other types of cancer, including anal, throat, vaginal, vulvar and penile (Gillison, Chaturvedi, & Lowy, 2008), cervical cancer is by far the most common of these (The New Zealand HPV Project, n.d). Because HPV is transmitted through sexual contact, cervical cancer is unique from other common cancers in its relationship to sexual activity, and the role of HPV needs to be considered. Some research has looked at the experience of being diagnosed with HPV.

International research has found mixed levels of awareness of the relationship between sexual activity, HPV, cervical screening and cervical cancer, with one study reporting that Latina women living in the United States had very limited knowledge, believing they need only participate in cervical screening if they experienced symptoms or engaged in risky sexual behaviour (McMullin, De Alba, Chavez, & Allan Hubbell, 2005), while another found that Brazilian campaigns which emphasised the role of sexual activity in cervical cancer increased participation for women overall, but decreased it for those who were no longer sexually active (Gregg, 2000).

In New Zealand, the small amount of research that has explored understandings of HPV has reported limited understandings around HPV, with a study by Chelimo, Wouldes and Cameron (2010) reporting that among university health science students, around half were unaware that HPV was transmitted through sexual contact and a similar number were unconcerned about their own risk of HPV infection. Another study reported two thirds of undergraduate health students were unaware of HPV being transmitted through sexual contact (Chelimo & Wouldes, 2009). Cook (2013) reported that being diagnosed with HPV was linked to feelings of shame, as well as feeling awkward and dirty. For the participants in Cook's study, who understood HPV as an infection transmitted through sexual contact, HPV was linked to sexuality and this added a moral component to it, creating a stigma around HPV infection.

The way in which cervical screening and HPV link to sexuality relates to a broader discourse of morality, which may impact on women's experiences. Research into the experience of cervical screening reported that for some women, allowing a person other than an intimate partner access to sacred parts of the female body was unacceptable (Lovell, Kearns, & Friesen, 2007), while discussion of cervical screening with others was unacceptable to women because of its link to sexuality, a morally taboo subject (Foliaki & Matheson, 2015; Jameson, Sligo, & Comrie, 1999). Fear and shame around a positive smear or HPV test result (Cook, 2013; Jameson, Sligo, & Comrie, 1999) also highlights how cervical screening's use a screening tool is linked to sexuality and morality, as a positive result was linked to perceptions of a woman being promiscuous, which had a sense shame associated with it, as this was seen as an immoral thing to be (Mckie, 1995). The moral aspect of screening can be



seen in how screening may be used as a tool to regulate female sexuality through making visible their sexual histories.

### **Critique**

The research into predictors of cervical screening behaviour produces very little meaningful knowledge about cervical screening. Knowledge about predictors is useful for demonstrating patterns and identifying where inequities exist, but does not explore the nature of the relationship between predictors and screening behaviour. In other words, they can tell us what the inequities are, but not why they exist.

Research which explores barriers to cervical screening implicitly promotes compliance with screening as a desirable outcome and takes on a deficit-based view of women who do not participate in cervical screening (Howson, 1999). A deficit approach looks at differences in health and health behaviour and conceptualises them as problematic, while assuming that engaging in prescribed health-related activities is desirable and morally neutral (Howson, 1999; Mckie, 1995). Approaches such as this problematise those who choose not to participate, and adopt changing individual behaviour as their goal. The impact of this is that people become morally responsible for their health, meaning that those who fall ill or are unhealthy are seen as problematic or uneducated, and health is transformed into a moral issue (Crossley, 2001). These approaches mean that those who do not attain good health are perceived as bad, and may be subjected to penalties or sanctions, or be the object of education programmes to change their behaviours (Resnik, 2007).

Cervical screening is constructed as something which is beneficial for women's health, and which all rational women ought to participate in. Lovell, Kearns and Friesen (2007) reported this in women's discussion of cervical screening, where women talked about screening as something they should take part in, but at the same time without having knowledge about the actual purpose of it. Howson (1999) also explored this, reporting that women spoke about screening as something they ought to do, as a routine behaviour, and as something one does without questioning the act. Through this, cervical screening may be something that women are obliged to take part in, with their choices about what they feel is right for them removed or made invisible.



Howson (1999) described a theme of moral compliance in women's talk about cervical screening. The act of overcoming embarrassment to participate in smears was discussed as being linked to self-responsibility and a moral attainment of maturity. Women reported feeling a sense of obligation to other female family members and friends in driving their participation in screening, as well as in turn persuading others to participate. Screening was understood by these women to be an activity which all women are obligated to participate in, linked to responsibility to oneself and to others. This moral compliance, which transformed participating in cervical screening into a good deed that fulfils some kind of moral obligation, means that the choice of participating or not becomes a choice of being "good" or not.

Mckie (1995) similarly noticed a theme of compliance in women's discussion of cervical screening, in that women who choose not to participate in screening were considered to be irresponsible and incompetent. The moral dimension added to cervical screening here, passing judgement over and stigmatising those who do not take part in cervical screening, creates a punishment for women, making it difficult for them to decline to participate lest they be subjected to this stigma. At the same time, Mckie also reported that cervical screening was perceived by women as an act which gave them control over their own body. This framing of cervical screening could make it an empowering act for women, part of actions they take as an autonomous choice to improve their health, although still bound within a social context which makes health a moral issue and attaining good health part of responsible citizenship (Resnik, 2007).

Through research that adopts a deficit approach, focusing on barriers to screening, those who do not participate in screening are transformed into bad or irresponsible. At the same time, through research that locates screening within social or individual responsibility, those who take part are privileged and lauded. These ideas are based on an underlying assumption that participation in screening is a desirable outcome and function to reinforce this notion.

This type of approach assumes health behaviour is morally neutral, and erases the moral component which may be present. Cervical screening is, however, embedded in "a moral framework of self-responsibility and social obligation" (Howson, 1999, p.401) and needs to be explored within this framework. When considering a health behaviour, there is a need to

acknowledge that it is bound to social context, what is currently known about the health issue, and what the norms around health and behaviour are. For example, Lupton (2012) has described cancer as a moral issue, where if someone is diagnosed with cancer, they may be filled with a sense of guilt about ways they could have prevented it. In the context of cervical screening and cancer, that cervical cancer is linked to sexual activity, and is constructed as preventable by regular cervical screening, means that those who develop cervical cancer may face guilt or judgement by others for not participating in screening regardless of the meaning of screening to them, as well as for engaging in sexual activity if it is seen as morally unacceptable.

Research into health disparities can be criticised for failing to take into account political and social factors. By locating health within the control of an individual and promoting behavioural change, an assumption that all individuals have the power to change their behaviour is made (Mielewczyk & Willig, 2007). And by focusing only on differences and deficits, the moral component of health is ignored, while the notion that the prescribed health behaviours set out by those who shape health policy are desirable behaviours is unquestioningly adopted (Crossley, 2001; Resnik, 2007).

While cervical screening may be a prescribed health behaviour, recommended by health professionals and the Ministry of Health (2014b), it is important to acknowledge that this does not automatically make it something that all women ought to participate in. Prescribed health behaviours change over time, and in New Zealand the cervical screening programme itself is due to change completely in 2018, with proposed changes in the method of screening, age range and screening interval (National Screening Unit, 2016). It is important that recommended health practices are open to challenge, and that women are able to make informed decisions about what is right for them, based on their personal, spiritual and cultural views, as well as with balanced information on screening risks and benefits, without being coerced into cervical screening.

Research into barriers to screening, as well as implicitly promoting compliance with screening, aim to influence individual behaviour change. This type of approach ignores the many, multilevel factors which influence individual behaviour (Stephens, 2008). Even where social factors are acknowledged in the research (Lovell, Kearns, & Friesen, 2007), there is still an implication that the behaviour of an individual needs to be altered.

A great deal of historical and contemporary health research has sought to identify factors which underlie health behaviours, and to enact change on an individual level, which ignores the complexity of health behaviours and the social context in which they occur (Mielewczyk & Willig, 2007). It is necessary to critically examine health behaviours and issues, and place them in a broader context of the social practices in which they occur. The use of approaches which focus on factors influencing an individual's decision to participate or not participate in screening runs the risk of blaming an individual for choosing to not participating in screening. Even while acknowledging external factors, such as a lack of knowledge on the purpose of or availability of cervical screening (Foliaki & Matheson, 2015; Lovell, Kearns, & Friesen, 2007), the overall aim of the research is to change the behaviour of individual women. Research such as this, which assumes that behaviour is determined by attitudes, intentions and cognitions (Stephens, 2008), ignores the broader structural and social factors which shape people's health.

There has been a lack of sufficient research into women's understandings of HPV, and how this may be implicated in their understandings and experiences of cervical screening and cancer. The role of HPV in cervical cancer is largely missing from health promotional material related to cervical cancer prevention, with the HPV vaccination which was introduced to school-aged girls being marketed as preventing cervical cancer, rather than protecting against the sexually transmitted HPV infection (Parker, 2010), and information pamphlets on cervical screening containing minimal information on HPV transmission (e.g., National Cervical Screening Programme, 2012; National Cervical Screening Programme, 2013; National Cervical Screening Programme, 2014).

While Cook (2013) described a shame and stigma associated with testing positive for HPV, research has failed to explore how understandings of HPV, and its relationship to sexual activity, may be implicated in understandings and experiences in cervical screening, particularly for groups for whom the link between sexual activity and cervical screening is problematic (Foliaki & Matheson, 2015; Lovell, Kearns, & Friesen, 2007; Peters, 2012). In addition, there is a lack of research into the emotional impact on women of testing positive for HPV, beyond Cook's description of shame and stigma, in the context of broader implications for women around cervical cancer risk.

With the primary cervical screening test in New Zealand changing from liquid-based cytology to HPV testing in 2018 (National Screening Unit, 2016), and likely to highlight HPV's role in cervical cancer more so than has been done previously, it is important that research considers the role of HPV in women's understanding and experiences of cervical screening.

As is clear in the critique of the existing literature, cervical screening is linked to women's sexuality, is portrayed as a behaviour that all women should participate in, and has a moral component. Social factors are likely to play an important role in how these understandings of cervical screening are shaped.

Rather than focusing on identifying barriers to screening and adopting an unquestioning stance that cervical screening is a desired behaviour which all women ought to comply with, there is a need to take a critical approach. Research needs to explore how understandings of cervical screening are inextricably linked to discourses of sexuality, compliance and morality and to attend to the social structures which police women's bodies and sexuality.

### **Theoretical Framework**

There is a need for research which explores women's understandings and experiences of cervical screening and HPV, and which considers the social world in which women live and how their sexuality and health is surveilled and regulated.

Research ought to consider how knowledge is socially created, and how multiple realities or ways of understanding the world can exist and change across groups and time, and are shaped by social interactions and relationships (Gergen, 2009). The implication of this is that there is no objective way to experience reality, but instead people experience context-bound representations of reality. The human body, rather than being an object which can be understood objectively, is constructed through social action, to create a representation of the body built on social and cultural factors and experiences (Howson, 2004). This context-bound representation is produced through power relations, reflecting and reinforcing dominant ideas and maintaining certain power structures (Lupton, 2012). Representations of the body are gendered, and the female body is constructed in different ways across time and contexts (Howson, 2004). The female body in a health context can be constructed as vulnerable to illness, dependent on a paternalistic medical system to protect

and care for it (Turner, 2008), and as docile and obedient to medical orthodox (Bush, 2000). At the same time in another context the female body may be constructed as powerful, autonomous and empowered (Gunn & Douglas Varus, 2010; Rose, 1990). The reality of the female body that is drawn upon depends on the context and the function of that representation. The same can be said about cervical screening. Rather than there being an objective reality of cervical screening, as an effective tool to prevent cervical cancer, there is a need to look at how cervical screening is constructed in different ways depending on context and function.

With this in mind, in this research there will be no attempt to change women's screening behaviour, nor to assume that participating or not participating in cervical screening is right or wrong. Instead the research will aim to make visible the power and social structures which create the realities that people live in, and reflect on how these structures may be used to create and maintain inequalities (Gergen, 2009). It will consider how these structures construct cervical screening, whether as a useful health surveillance tool and an empowering act (Mckie, 1995), or as a way of subjecting the female body to surveillance, governance and policing (Bush, 2000; Howson, 1999).

To understand how power relations contribute to health inequalities, it is necessary to consider contextual factors, and not locate health solely within an individual. An approach which draws together aspects of sociology, anthropology and psychology can be used to explore social context and psychological factors (Stephens, 2008), and may be applied to research into women's understandings and experiences of cervical screening. Pasick and Burke (2008), in their research on breast cancer screening, reflected the limitations of social cognitive theories which try to identify how attitudes and intentions predict health behaviour. They emphasised a need for an anthropological approach to research into screening, which explores meanings of health and illness to people, and how these are informed by broader social factors. An approach which incorporates these factors works to consider how health is socially bound, but at the same time operates under the assumption of an objective reality which can be known, rather than considering how knowledge itself is socially constructed (Gergen, 2009).

Adopting a constructionist approach allows us to consider the social construction of reality. It goes further than an anthropological approach, which explores how knowledge and

experiences are shaped by social context. Within this framework, reality can be thought of as constructed by one's social relationships, and by language itself (Gergen, 2009). This opens up the possibility of alternate realities, or ways of interpreting the world. For cervical screening, this means not accepting without question the reality of cervical screening as a desirable health behaviour which women should participate in, and instead considering how this reality is shaped by the social world, through history and culture, and by social structures which control power relations. It is important to consider the function of different representations of cervical screening, and how they are inextricably linked to cultural and social factors. For cervical screening, the construction of the practice as an effective tool which women should participate in to protect their health removes from consideration female bodily autonomy, making control over one's own body invisible and irrelevant. Instead, it promotes compliance and submission to the medical profession, maintaining a power imbalance between a paternalistic medical system and vulnerable women (Gunn & Douglas Varus, 2010; Lupton, 2012). It places women's bodies and sexual behaviour under scrutiny, where they may be judged for behaviour that is framed as unacceptable or immoral, and where their lives may be surveilled and controlled (Howson, 1999; Mckie, 1995).

The multiple realities that exist and are experienced draw upon discourses, which are ways of understanding and describing the world (Gergen, 2009). Discourses are used to make sense of a person or object, and are embedded within their historical, social and cultural context (Lupton, 2012). Discourses can be found within texts, such as people's speech, books, or media, and produce the social reality that is experienced (Phillips & Hardy, 2002). Discourses, and the way they construct reality, serve a function. They may be used to maintain or challenge social and power structures and may be more or less widely used or drawn upon (Parker, 2005).

Discourses which are widely used can be described as dominant discourses, and these are discourses which are readily available when considering an object or topic, because they are more familiar, and they become more widely used, familiar and dominant when they serve a social function (Gergen, 2009). Dominant discourses tend to be those which maintain long-held power structures, for example gender hierarchies, and through the realities they create power can be exerted over groups to create or maintain inequalities (Gergen, 2009;

Van Dijk, 1996). Other discourses may be less widely used, but by creating alternative realities they can function to challenge power structures and inequalities (Van Dijk, 1996), such as by marginalised or disempowered groups.

Discourses constrain ways of experiencing the world, and create different realities. By analysing discourses in critical research, the way in which experiences of the world are constrained by social and power relations can be made visible, and as a result these discourses can be either maintained or challenged (Parker, 2005). It is important to consider the function a discourse has, what power structures it maintains, and who it privileges or marginalises.

The discourses which surround cervical screening are multiple and in some ways contradictory. Medical discourses generally position patients as helpless and doctors as experts (Lupton, 2012), and may be drawn upon in the context of cervical screening to create an obligation to participate in screening. Discourses of morality surround cervical screening, and have been explored somewhat in research, such as by Howson (1999) and Mckie (1995). Women are morally obliged to participate in screening, and by not doing so are seen as failing (Howson, 1999), yet screening's relationship towards sexual activity and promiscuity and the risk of sanction and judgement in the case of a positive result can conflict with this obligation (Mckie, 1995). A dilemma is created for women, where they are morally bound to participate in screening, but risk being seen as immoral when they do. Discourses of femininity may be drawn upon to position women as passive and obedient, as Bush describes, cervical screening is constructed as "just part of being a woman" (2000, p.429).

International discourse analysis research which has explored understandings of cervical screening has demonstrated the multiple discourses surrounding it, which can maintain power relations through discourses of cervical screening as sensible, vital, or morally obligated (Darwin & Campbell, 2009; Howson, 1999), and of women who participate in screening as intelligent, responsible and mature (Howson, 1999; Todorova, Baban, Balabanova, Panayotova, & Bradley, 2006). Alternative discourses can challenge these power relations, such as those of cervical screening as unnecessary, or as interfering with God's will (Darwin & Campbell, 2009; Pop, 2015). In the context of cervical screening, alternative discourses can provide a tool to empower women and facilitate their autonomy



and control over their own bodies (Pop, 2015). By critically examining the discourses surrounding phenomena, power structures are made visible, and it becomes possible to challenge these structures for how they constrain people's behaviours and understandings, as well as how they create and maintain health inequalities (Lyons & Chamberlain, 2006).

Cervical cancer, and cervical screening as a tool to prevent it, is a women's health issue. With this in mind, it is important to incorporate a feminist theoretical framework to this research. Ironstone-Catterall et al. (1998) argue that a feminist approach enables research to acknowledge women's lived experience, to see women's health issues as "intricately woven in a fabric of social inequality" (p.3), to empower women and to enact change. While traditional psychological and health research has aimed to be objective, openly adopting a feminist approach recognises that it is neither possible nor desirable to be objective and neutral when conducting research. By taking a feminist approach to research on cervical screening, it is possible to "embrace rather than avoid" (Rogers, 2006, p.351) the social and political factors that are inevitably linked to health. This is well-aligned with a constructionist approach, with both describing reality as produced through social relations and structures. A feminist approach specifically focuses on how these structures have been and continue to be used to disadvantage or control women.

A feminist approach acknowledges that psychological and health research has traditionally disadvantaged women, whether by constructing them as other, inferior or dangerous (Lupton, 2012; Shuttleworth, 1990; Turner, 2008), and actively challenges this, with a goal of empowering women and working towards gender equality (Ironstone-Catterall, et al., 1998). This research will explore women's experiences of cervical screening within the context of their lived experience, and the conditions and structures which have worked to maintain inequality.

This research will aim to conduct a critical analysis of the experiences of and understandings around cervical screening of New Zealand women, incorporating a constructionist epistemology and drawing on a feminist theoretical framework to conduct discourse analysis. It will avoid a deficit-based or individualised focus, and instead adopt a broader approach which considers the ways in which women's bodies are subject to surveillance and control.



## Methods

### Methodology

Discourse analysis encompasses many approaches, and the approach used in this research draws upon critical discourse analysis, specifically Foucauldian discourse analysis, with a focus on how language constructs a reality which privileges some worldviews over others, and creates and maintains power imbalances (Phillips & Hardy, 2002). The emphasis is on how the discourse constrains the ways in which people can understand and act in the social world. When analysing participants' responses, and identifying discourses, it was important to reflect on the function of the different webs of discourse, in how they made available some ways of understanding and moving through the social world, privileging ones which contribute to unequal power relations.

The way in which we view the world is constrained through the subjectivities made available to us, and the way in which we communicate creates different realities, which can be used to maintain or challenge the social order (Phillips & Hardy, 2002). By critically examining the discourses surrounding phenomena, power structures are made visible, and it becomes possible to challenge these structures for how they constrain people's behaviours and understandings, as well as how they create and maintain health inequalities (Lyons & Chamberlain, 2006).

Power relations can be maintained by privileging discourses around cervical screening that encourage compliance and subject the female body to surveillance. Power relations can also be challenged with alternative discourses which resist the dominant discourses around screening. Alternative discourses can provide a tool to empower women and facilitate their autonomy and control over their own bodies (Pop, 2015).

Cervical cancer, and cervical screening as a tool to prevent it, is a women's health issue. With this in mind, it was important to incorporate a feminist theoretical framework to this research. By using a feminist and social constructionist theoretical approach and discourse analysis methodology, it is possible to explore how the discourses which surround cervical screening are used to maintain or challenge power imbalances.

**Ethical considerations**

Ethics approval for this research project was obtained from the Massey University Human Ethics Committee: Northern, Application 16/07. A full application was completed and I requested to meet with the ethics committee as they considered the application, to clarify and answer any questions they had.

*Protection of participant information and right to withdraw*

Participants' privacy was well protected throughout the research. A password protected tracking document was stored on my computer with contact details and interview time and location. Recordings of interviews were moved from the recording device to my password protected laptop following the interview, and copies given to the research supervisor. Transcripts of the interviews were also stored securely on my computer and copies given to the research supervisor. Hard copies of consent forms were given to the research supervisor to store securely.

Upon completion of the research project, recordings were to be deleted as they contained identifiable material. The research supervisor was to retain secure copies of the anonymised transcripts and consent forms for five years, and then destroy them. Contact details of those who requested receipt of a summary report were added to a list with other interested parties, also stored on my password protected laptop, to be contacted later. The list was to be deleted after the summary report was sent.

When writing up results, anything that could be used to identify participants was removed, such as mention of place of work/study, names of any individuals or health providers, and their own names. Pseudonyms were used in writing up results, which were chosen randomly from a list of popular female names.

Participation in the research project was completely voluntary, and participants were reminded of their right to withdraw several times throughout the interview process. Petrol vouchers were given to participants as a thank you for their time. These were given before the start of the interview, so that there was no financial incentive for participants to continue with the interview if they did not want to. Participants were made aware of their right to stop the recording at any time, refuse to answer anything, withdraw some or all of

what they had said, stop the interview at any point and ask me to delete the recording. Following the interview, participants were told they could withdraw from the research up until two weeks following their interview, after which point as data analysis may have commenced it would be very difficult to tell which of the data was theirs and remove it.

#### *Participant and researcher safety*

The research topic of women's experiences of cervical screening may have been of a sensitive nature for some women, and there was a possibility that a participant might experience some distress during an interview. This was planned for by ensuring that I adopted an empathetic stance, but avoided engaging in any type of counselling, and if a participant showed a sign of distress, I would check if they wanted to stop the interview, and following the interview give them the contact details for a service which could offer counselling support, such as Lifeline.

To ensure researcher safety, it was agreed that interviews would take place in a public place, such as university or a library, and that the supervisor would be made aware of when and where each interview was happening. I ensured I had good support structures in place and could debrief with the research supervisor about anything I felt affected by.

#### *Cultural Consultation*

It was important that this research project was respectful and meaningful for Māori, and applied the principles of te Tiriti o Waitangi/the Treaty of Waitangi. Consultation was sought with the kaumatua for the Massey University Albany School of Psychology, Nephi Skipwith about how to ensure this research would be respectful and meaningful for any wahine Māori who participated. It was agreed that it was important to acknowledge that subject of cervical screening was tapu, as te whare tangata (the womb) is the place where life comes from. It was also important that the interview was driven by the participant, and the kaumatua suggested a whakapuaki or conversational style for the interview so that participants could share their purakau or stories in a way that was meaningful for them. The kaumatua advised that the research should follow a powhiri process of engagement, based on building whanaungatanga with participants. The kaumatua also recommended that I

consult with a wahine Māori or kuia, given the research topic of cervical screening. I met with a colleague, Dr Jade Le Grice, who is a kaupapa Māori and mana wahine researcher at the University of Auckland. She shared with me some Te Ao Māori including some Te Reo Māori relating to te whare tangata and how to approach this respectfully with wahine Māori.

### **Participants, recruitment and selection**

#### *Participants*

Participants were 10 women living in Auckland who were aged 20 to 30 years. Given the research question of women's experiences of cervical screening, it was important to limit the participants in the research project to those who identified as women, to explore their experiences. There was discussion between myself and my supervisor about whether to further define this as people who were born biologically female. GLAAD recommends avoiding use of the term biologically female, as this can be a problematic term for trans individuals, and that 'assigned female at birth' is a more appropriate term (GLAAD, n.d.). It was agreed that it was not necessary to limit the participants to those who were assigned female at birth, as there is a lack of research into the experience of trans or non-binary people accessing cervical screening, despite the health inequities experienced by these groups (Anderson, McNair, & Mitchell, 2001). It was agreed that if any trans or non-binary individuals wanted to participate, they would add important knowledge about the understandings and experiences of cervical screening for a group that has previously been largely invisible in health research. It was also agreed that it was not necessary to specify that participants 'identify as female' as this may confuse some individuals who are unfamiliar with this term and discourage them from participating. By limiting the call for participants simply to women, the term was broad enough that any individual who identified as a woman and wanted to take part was invited to. None of the participants in the research expressed any issues with this terminology before, during or after the interviews.

Participants needed to be living somewhere in the Auckland area, for practical purposes as it would not be feasible to travel beyond Auckland for this research project. Auckland has a

diverse population, spanning many ethnicities, sexual orientations, religions, education levels and income brackets (Statistics New Zealand, n.d.), but it is important to acknowledge that the experiences of women elsewhere in New Zealand may be different.

The lower age limit of 20 was selected as the age at which women are invited to join the cervical screening programme in New Zealand (National Screening Unit, 2014b), and therefore would have experience of being invited to take part in cervical screening, and potentially of participating in screening. The upper age limit of 30 was chosen for three reasons. First, to obtain a rich description of experiences of being invited to take part in screening, and of first screens, participants for whom these experiences were more recent in their memory were selected. Second, given that discussing cervical screening may be a sensitive topic for some women, it was agreed that young women may be less uncomfortable discussing this subject with a young researcher such as myself. By using participants who were of a similar age group as myself (aged 24), it was thought that there would be more *whanaungatanga* and it may be easier to build rapport, and therefore participants would both feel more comfortable sharing their stories, and would share more detail. Third, there is a paucity of research which focuses on younger women's experiences of cervical screening, as much of it focuses on older women (Howson, 1999; Lovell, Kearns, & Friesen, 2007; Mckie, 1995).

Ten women were interviewed for the research. There are no firm, widely-accepted guidelines about the number of participants that should be used for research involving qualitative interviews. Given the large amount of data generated during qualitative interviewing, it was important that the workload involved be manageable for a one year Masters research project. It was also important that sufficient participants included to allow common discourses to be identified. Other research that was reviewed used participants ranging from 6 to 34 (Armstrong, James, & Dixon-Woods, 2012; Buetow, Janes, Steed, Ihimaera, & Raina Elley, 2007; Lovell, Kearns, & Friesen, 2007; Peters, 2012). It has been suggested that the guiding principle for sample size be saturation, meaning the point where the inclusion of additional data does add any new knowledge to topic being explored (Mason, 2010). For this research, where the purpose was to obtain depth of knowledge over breadth, it was decided that 10 participants would strike the balance between sufficient for reaching saturation point, without compromising on depth of analysis.

### *Recruitment*

A participant information sheet was created (see Appendix A) which outlined the purpose of the research, what participants could expect from the interview, and that participation was entirely voluntary and they could withdraw at any point.

The participant information sheet was initially emailed to the mailing list of Women's Health Action, a small women's health promotion organisation, where I work part-time (see Appendix B). The organisation has a mailing list including a number of women and women's organisations, and permission was granted by the Director to use this list for recruiting participants. Women's Health Action has a commitment to promoting better health outcomes for all women, and is not affiliated with the National Screening Unit, nor does it have a vested interest in promoting cervical screening. The information sheet was sent to this group, and as a result the Auckland Women's Centre put the information sheet up in their premises. After around two weeks, no participants had responded, so other methods of recruitment were used.

Snowball sampling was used by asking several friends and family members to pass the information sheet along to anyone they knew who might be interested in taking part. It was communicated clearly that participating was entirely voluntary, and that participants could not be someone with whom I was acquainted. Posts were also shared to two Facebook groups, the Massey University Extramural Community (see Appendix C), and the Auckland Women's Centre (see Appendix D), inviting anyone interested to contact me.

### *Selection*

Selection of participants was made based on those who got in touch first. No participants were excluded based on age, ethnicity, or other demographic factors. There were two reasons why participants who were interested in taking part were excluded. First, several of those who got in touch were outside of Auckland, and interested in taking part over Skype. It was decided that given that the research topic may be a sensitive topic, it would be better for interviews to take place in person, so that participant safety could be better protected. Others who were interested in participating were excluded if they were acquainted with the

researcher. In the event of sensitive information being disclosed, it was agreed that it would not be ethical for me to have an ongoing personal relationship with any of the participants.

### *Sample*

Demographic information was collected for 8 of the 10 participants. Participants ranged in age from 21 to 27. Participants self-identified their sexual orientation and cultural identity. Two participants were bisexual and six were heterosexual. Four participants identified as New Zealand European, three identified as New Zealand European/New Zealand Maori, and one identified as Indian New Zealander.

### **Interview Procedure**

#### *Initial contact*

Participants who saw the information sheet and were interested in participating were invited to contact me by email. They were then asked for a convenient time to be called on the phone, during which time I checked they had read the information sheet and understood everything, and whether they had any questions about the research at this point. I then asked them when a convenient time for the interview would be for them, and what location they would like the interview to take place in. I also checked for any cultural or access requirements. Following the phone call, I emailed the participant to confirm the interview time and location, and encourage them to contact me if they had any questions. On the day before or day of the interview, I also texted them to remind them that our interview was scheduled, and to ask them for food and drink preferences.

#### *Interview setting*

Participants were able to choose the location of the interview. It was decided that this should be a private room in a public place, rather than going into the participants' own homes, to guarantee the safety of the researcher. Interview locations were either a room

reserved on campus at Massey University, a room hired from an Auckland library or community centre, or a room reserved at the Women's Health Action office.

### *Interview process*

The interview process was planned with an interview schedule (see Appendix E). Upon arriving at the interview location, I greeted and introduced myself to participants, and thanked them for coming. This was followed by introductions and sharing of food and drink, with an informal chat to build whanaungatanga and rapport. I then went over the information sheet with the participant, emphasising who I was, the purpose of the research, and what it would involve. I explained that I would be recording the interview and how their privacy would be protected, and reiterated their right to withdraw. I also drew their attention to the contact information for myself, my supervisor and the Massey University Human Ethics Committee in case they had any questions or concerns after the interview. Participants' understanding of the information sheet was checked, and they were given an opportunity to ask any questions and reminded that they could ask any as they came up during or after the interview. Participants were then given a consent form to sign (see Appendix F). I also let participants know if they were interested in the results of the research, they could add their contact information to the consent form and I would send them a summary report after the research was completed. Participants were given a \$20 petrol voucher to thank them for the time, and reminded that they were free to leave at any point.

The interview was recorded using a recording device placed on the table. I used a list of interview questions (see Appendix G) that were broad and open-ended, designed to encourage participants to speak freely on the topic. The interview adopted a whakapuaki, conversational style, driven by the participant rather than the researcher, so that participants could share their purakau or stories in a way that was meaningful to them, rather than being restricted with a rigidly structured interview. It was important that participants controlled the narrative, since the topic being discussed was tapu and of a sensitive nature. When a participant spoke, minimal encouragers such as nods were used to encourage them to continue speaking without interruption. For each of the broad interview



questions, there were more specific questions to probe for more depth if required. The interviews were informal, with laughter shared between researcher and participant at points. It was important to acknowledge that cervical screening was an experience that is shared between participant and researcher, and this was done through empathetic responses and sounds, for example 'yeah, I've been there' when a participant joked about their experience. This functioned to create a safe space for participants to share their stories. With each participant, there was variation in the extent to which probing questions were used, and the order of the questions depended on the flow of conversation, to cover the following topics:

- understandings around cervical screening and HPV
- experiences with cervical screening
- feelings of shame and stigma
- compliance and obligation
- sexuality
- physical health
- family
- spiritual/religious beliefs

After asking all my questions, I checked with participants if there was anything they felt had been left out of the interview. A brief reflective session was conducted. This was a way to review what had been discussed, check my understanding of what was said and clarify anything that was unclear, as well as for the participant to remove anything that they did not want included in the results. If, during the interview, the participant indicated a desire to learn more about cervical screening or cancer, I offered them some resources from the National Cervical Screening Programme, making it clear that these were Government-produced resources (see Appendix H). At the end of the interview, participants were thanked once again for their time and offered another opportunity to ask any questions.

As interviews progressed, I found that the original list of interview questions were not always sufficient to cover all the topics I was interested in, as I wanted to explore HPV in more depth, as well as the role culture played in experiences of cervical screening. I added questions in that related to these topics, and these were included in subsequent interviews,

and led to developing a revised list of interview questions for later interviews (see Appendix I). Both the original and revised versions of the interview questions can be found in the appendices.

## **Data Analysis**

### *Transcribing*

Before the data could be analysed, it first had to be transcribed. It was decided that I would complete the transcribing myself, in part to avoid any ethical issues around privacy by involving a transcriber, as well as being important for reflection to continuously improve how the interviews were conducted. Transcribing involved listening to small sections of the recording, usually about five seconds at a time, and writing them as they were heard, then replaying them to check they were heard correctly. After a transcript was fully written, I would listen to the recording through again, pausing to make any corrections needed.

Initials were used to denote who was speaking at any time, with HC used for the researcher, and P used for the participant. Later, these initials were replaced with participants' pseudonyms for use in writing up results of the research.

When transcribing recorded audio into written text, the loss of tone of voice can make analysis difficult. This was mitigated as much as possible, by adding in parentheses if a statement was spoken sarcastically, was said exceptionally loudly or quietly, or whispered. I avoided interpreting the participants' tone of voice too much, such as by adding in descriptions such as '(calmly)' given that this is ambiguous and subject to interpretation, and so could distort how the data was analysed.

To record speed of talking, an ellipsis was added if a participant paused during speaking, with a single ellipsis (...) for a short pause of around three seconds, and additional ellipses added for longer pauses. For example, if someone paused for three seconds, I would use one ellipsis, if they paused for approximately six seconds, two ellipses would be used (... ...) and so on. If a speaker stopped speaking during a word, such as to say something different or clarify what they had said without pausing, or was interrupted, a dash (–) was used.

Non-verbal sounds were also transcribed as they were heard, such as 'um', 'er', 'aw' etc. and laughter was included in parentheses and attributed to who the laughter came from, e.g. (HC: laughs). During the interview, I used minimal encouragers, which were included in the transcript where they happened in parentheses, e.g. (HC: mmm). If something a participant was said was unintelligible, this was noted on the transcript in parentheses as a replacement for the word or phrase.

### *Analysis*

Willig (2008) suggests that when conducting a Foucauldian discourse analysis, the first thing that needs to be done is identify discursive objects that the research is interested in. This refers to the broad concepts that relate to the research question. In this research, the discursive objects to be analysed were the medical profession and doctors, cervical screening experience, human papillomavirus (HPV), sexuality, the purpose of cervical screening, cervical cancer, being a woman, and culture (including family and friends). Following identifications of the discursive objects, all text which related to each object was identified and drawn together into a separate document. Deciding whether text related to each object involved a close reading of the text for implicit references as well as explicitly stated mentions of the object.

For example, an explicit reference to the discursive object of sexuality might include 'because it's so sexualised, like have you had sex? Yes? Okay you need to do this', whereas an implicit reference might be 'because I receive the Depo shot it was at the same time'. While sexuality itself is not referred to in the latter statement, the reference to screening as part of accessing contraception locates it within sexuality.

Many sections of the text included multiple discursive objects. For example, one response from a participant:

*Olivia: "Like I know they're a doctor and all but this is just... it's kind of like that sexual taboo thing like if a guy's down there it's for a particular reason so.. I just yeah I didn't feel comfortable at all, and it's not the kind of procedure you want to tense up during."*

This excerpt includes reference to the medical profession, in talking about the doctor doing the procedure, as well as sexuality in terms of being taboo and a space usually reserved for sexual activity, and finally to cervical screening experience in the mention of feeling uncomfortable and not wanting to tense up.

Every discursive object related to a response was identified and noted, so that a full analysis could be done that did not exclude any relevant data. As discursive objects were identified, the function they served was analysed. Each discursive object that related to the research question played a role in constructing cervical screening, and were located within discourses. The broader discourses that discursive objects fit into were identified, based on how the discursive object constructed cervical screening, and how it constrained ways on understanding and experiencing the world. For example, for the discursive object of the medical profession and doctors fit in to multiple discourses. Medical discourse positioned doctors as experts and patients as passive, discourses of femininity positioned women as vulnerable and needing care, and a discourse of morality transformed listening to doctors' instructions into a moral issue.

Different discourses were explored in depth, as well as the function they served to construct cervical screening and the options available to women. The different subject positions and subjectivities that were made available by different discourses were also explored.

Discourses construct specific ways of acting and viewing the world differently, and in doing so creates different subject positions for those who draw upon or resist these discourses. For example, discourses of neoliberalism, which emphasises individual responsibility, positions those who take part in screening as responsible and autonomous, while medical discourse can position those who take part in screening as obedient.

Through analysis, three broad concepts which encompassed each of the discursive objects were explored, that of choice, morality, and vulnerability. These were identified as broad webs of discourse which needed to be explored, as they made available different ways of constructing the world and were closely linked to power relations. They worked together to privilege specific courses of action and maintain the status quo, and thus were of interest in this research exploring cervical screening from a feminist, constructionist standpoint.

Within each of these broad webs of discourse, different subjectivities were identified. For example, within the broad concept of choice, cervical screening could be either something that was done autonomously, where women freely chose to take part because they wanted to; as routine, and part of being a woman; or as something which was expected of women, with non-compliance being censured and disapproved of by others.

The original research question aimed to explore experiences of cervical screening and HPV as two primary topics. Participants did not discuss HPV in great detail, and so as data analysis was conducted, HPV became a secondary topic, linked into notions of choice, morality and vulnerability but less salient for participants. As such, the research became focused on cervical screening, with HPV being explored as an auxiliary component.

### Findings & Discussion

Three broad webs of discourse were identified in the analysis of participants' responses: choice, morality and vulnerability. Each of these included different, sometimes contradictory discourses, which functioned to create different subjectivities for participants, providing ways for them to understand and move through the social world. These webs of discourses constructed cervical screening in different ways dependent on the function at hand, drawing upon different discourses and interwoven with power structures. Each of these webs of discourses will be explored in turn, first through identifying the different functions they serve, followed by the ways they were drawn upon by participants. Finally, the ways they work together to construct cervical screening will be analysed.

#### Choice

The ways in which choice was implicated in women's experiences of cervical screening was explored during analysis, and was framed in three key ways: as an autonomous choice; as routine; or as obligatory. These contradictory ideas were expressed to different extents by different women, but appeared to be held and drawn upon by each of them, depending on how they functioned to construct different ways of experiencing and understanding cervical screening. Each of these ways of framing cervical screening will be considered, and then the ways in which participants drew upon them explored.

#### *Cervical screening as an autonomous choice*

At points, participants expressed how important cervical screening was to them. In discussing the purpose of screening, they voiced confidence that screening was a useful tool in preventing cervical cancer, that if there was anything wrong it would be caught early. Taking part in cervical screening was a proactive step to protect their health, and something they chose freely for themselves.

*Isabella: "It's all these really easy preventative things that we can do to make sure that... you know to catch it early and I think if we can do something little to catch it early it's a million times better than you know finding out you've got it and having to go through that treatment."*

Zoe: *"I was kind of like aw I don't wanna be missing something and like yeah just I take my health quite seriously... I'm terrified of being infertile because I really want kids so it was partly around that, sort of like oh well I don't wanna get cancer, and like if there is something there I want them to know."*

Chloe: *"I feel like it's preventative and why wouldn't you, you know, if you are gonna get something like that, if you can find it three years before it's gonna get worse and you can stop that earlier why wouldn't you? So yeah it's definitely a choice, I choose to go get them."*

Charlotte: *"I felt like really good about [having a smear] afterwards, that like I'd done it and ticked it off... I don't want to get sick of something that I could've- I'm quite like health anxious, health conscious person anyway, so I would wanna know, I always wanna know what's going on with my health."*

Some participants drew parallels with taking part in other types of screening or described cervical screening as part of preventative health care. Cervical screening was categorised with other activities they took part in to protect their health, as something they proactively sought out as a check-up to ensure their health was continuously protected.

Abigail: *"I think it's really important...I can't see like a reason why you wouldn't do that [get a smear] because you'd do it for everything else... you know, like you'll still check yourself for breast cancer."*

Chloe: *"I suppose it's like going to the dentist to have your teeth cleaned, you know they're all just checked up."*

Mia: *"I see it just as... like I need my Depo shot, or just like I need my annual medical check-up or if... I need to get my eyes you know checked by the optometrist."*

Several participants considered the possibility of false positives, where an abnormal result is obtained when there are actually no cell abnormalities, which run the risk of creating anxiety for women or for leading to unnecessary overtreatment. For those who discussed this, the potential consequences of a false positive were not significant enough to impact on their choice to take part in screening. The anxiety and overtreatment that might occur was preferable to the risk of abnormal cell changes going undetected.

Lily: *"I still think it's better to be safe than sorry so really like a few months of ... mildly worrying about it now and then and for it to be nothing is better than for it to be like not going and then getting cervical cancer."*

Chloe: *"I'd rather have to go through it all and be told it's fine, than the other way round and be like oh we didn't catch it last year sorry."*

Most participants had described being invited or asked to come in for their first smear by medical professionals. However, one participant had actively sought out their first smear for themselves, and asked their doctor for one.

Lily: *"When I was 20 I had a doctor's appointment and then I asked while I was at the doctor's appointment about it, and then they did it then"*

Some participants, when thinking about declining smears, felt confident about being able to say no. They described no concerns about their ability to comfortably decline the procedure.

Olivia: *"If I say no they can't do it, so well if I say it they can't force me to lie down so... you know if I didn't want to I'd say no."*

Chloe: *"I could not go... you know I could not go."*

These participants drew upon a medical discourse as they described their choice to take part in cervical screening to protect their health. Within this discourse, cervical screening is an effective test used to prevent cervical cancer. Screening is constructed as built on a strong evidence base and as necessary to protect women's health. Part of this discourse positions medical professionals as experts, who know what is best for women's health, and have their best interests at heart by offering cervical screening. The medical discourse that is drawn upon here also appears in the messaging given to women through interactions with medical professionals, online information, screening invitations and leaflets. Cervical screening as an effective prevention tool is constructed through official messaging from government and medical officials, and through resources produced by them (Armstrong, 2007), as well as through family and friends (Lovell, Kearns, & Friesen, 2007). Many of the women in the present study reported finding out about cervical screening for the first time in the context of receiving the HPV vaccination as teenagers, or as part of sexual or general healthcare such as accessing contraception, and drew upon a medical discourse when



describing the reasons why they chose to take part in cervical screening, based on its efficacy at protecting their health.

Cervical screening as an autonomous choice also linked in with a discourse of empowerment. Within this discourse, patients are empowered, encouraged and strengthened to have control over their health and make informed decisions freely, without coercion or external influence (Wiggins, 2012). Many of the participants claimed ownership of their decisions around cervical screening. Although the act of taking part was part of following medical advice, the information they received on the purpose of cervical screening was used to help them make an informed choice free from pressure. This creates a positive construction of cervical screening, as a tool which women utilise to protect their health.

The history of cervical screening in New Zealand is somewhat controversial, particularly the 'unfortunate experiment' which led to the Cartwright Inquiry, the establishment of a national cervical screening programme, and of a legislated code of rights for consumers (Coney, 1988; Women's Health Action, n.d.-a). Dominant medical discourse at this time positioned doctors as experts, and patients were expected to comply with their instructions. Following this, there has been an increased focus on patient autonomy in healthcare, and people's rights to make informed choices, with guidelines emphasising patients' rights (HDC Code of Health and Disability Services Consumers' Rights Regulation 1996; Medical Council of New Zealand, 2011). Participants drew upon an empowerment discourse, but at the same time medical discourse which positions medical professionals as experts acted to privilege particular choices of action, those aligned with the recommendations of medical professionals. Participants made an informed, autonomous choice to take part in cervical screening, but this decision could only be based on the information made available to them through medical discourse which encourages participation. The act of cervical screening was positioned as the sensible choice which protected their health, and alternative ways of acting were not made easily available to them.

Participants positioned themselves as autonomous and making choices for themselves, and actively engaged in and made decisions about their health. However, the context in which these choices were made needs to be considered, particularly how the available ways to act were limited, and for these women, to make a smart choice to protect their health and comply with the recommendations of the medical profession was the dominant, legitimised

course of action. To make an alternative choice was an option they could take, but it would defy medical orthodoxy and was framed as undesirable, since it would not be the sensible, recommended choice, nor the safe choice according to medical advice.

### *Cervical screening as routine*

Ways in which cervical screening was constructed as part of routine health practices, adopted without critical consideration on the advice of medical professionals, were also explored. Participants had faith in the medical system, that it had their best interests at heart and they could rely on medical professionals' advice that screening was something they should do.

Abigail: *"If it needs to be done it needs to be done."*

Olivia: *"It was fine, it was just another thing that you just do every couple of years."*

Isabella: *"I still think they're just like one of those things that you suck it up and do."*

Mia: *"It was just another medical ... like a check-up would be I guess."*

Chloe: *"It was just kinda like oh we just have smears because it's what we do."*

Starting screening was seen as part of getting older, and reaching a certain age, as well as part of becoming sexually active. It paralleled a transition from childhood to adulthood.

Eva: *"I think the doctor just said um 'look you're sexually active and you're 20, we need to start doing regular screening checks' ... I remember it being quite like just sort of normal, yeah very routine... I sort of just knew it was like a routine thing, you know, as I was at a certain age."*

Olivia: *"It was more kind of like oh you're sexually active... we need to do this...okay sure"*

Isabella: *"They [medical professional] just said, 'you're at that age... where you have to have them'... it's one of those things that you've gotta get done and you just go and do it."*

The routine and expected nature of cervical screening was also seen as part of what it means to be a woman by many of the participants. The notion of cervical screening as part

of being a woman was established by some through their own understandings, and by others was directly framed as such through conversations with family members, particularly mothers.

*Sophie: "I like mentioned it to my mum, she was like 'yeah it's just one of those things, you're a woman you have to do it you know.'"*

*Olivia: "It's just part of being a female... is that important stuff is inside us."*

For some participants, it was difficult to comprehend why someone would not choose to take part in screening. Cervical screening was seen as a simple, easy thing that had positive effects on health, and so it seemed logical to participants to accept it.

*Abigail: "Like it's offered to you so why wouldn't you take it?"*

*Sophie: "I feel like if we're offered umm if we're offered something that could potentially prolong and improve the quality of our lives I don't see why you would decline it?"*

The description of cervical screening as routine, which has been seen in other research (Bush, 2000; Howson, 1999) draws upon several discourses. A discourse of femininity and what it means to be a woman is used. Discourses of femininity construct a woman as obedient and docile (Gunn & Douglas Varus, 2010), as well as casting her in the role of health promoter, aware and careful to protect her own health (Lupton, 2012). For the participants, part of being a woman meant opening one's body up to surveillance and treatment by doctors and medical professionals. Participants commonly cited the recommendations of medical professionals, or following what their mothers, sisters and friends did, as the reason for taking part in cervical screening, and did not question their participation. Cervical screening simply formed part of what you do while navigating the social world as a woman, and beginning cervical screening was contextualised as part of becoming a woman, reaching a certain age and becoming sexually active. Part of what it means to be a woman within a femininity discourse is to subject the body to medical surveillance (Lupton, 2012), and so being a woman means opening up private spaces in the body to be examined.

A medical discourse is drawn upon again to construct cervical screening as routine, where medical professionals are the experts, and participants take on a more passive role as an obedient patient. The recommendations of medical professionals are accepted and

participants comply with them. A discourse of empowerment is missing, as participants draw upon medical discourse and a discourse of femininity to position themselves as women and as patients, acting as obedient women who take care of their health by following medical orthodoxy and the example of the majority. Medical discourse constructs screening as a simple procedure to effectively prevent cervical cancer, and so for many women, to take part in screening is routine (Armstrong, 2007). Participants cannot see why they would not want to take part in screening. That one would defy the recommendations given by a trustworthy medical professional seems nonsensical. The participants have lived and experienced this dominant discourse where medical professionals are wise and will protect one's health if they comply with their instructions. Cervical screening is simply par for the course, a routine aspect of what you do as a woman.

#### *Cervical screening as obligatory*

Participants talked about how they felt about not taking part in cervical screening, including some of the reactions they might expect from medical professionals if they decided not to participate. They discussed how a decision to not take part might be met with disapproval, or be difficult for them to act on. The effect of this was to construct screening as obligatory, something they were compelled to take part in. Participants offered accounts of both real and perceived pressure to take part in screening, and described the feelings of awkwardness at the prospect of declining screening when speaking to a medical professional.

*Sophie: "I mean, at the end of the day it is your choice if you wanna go or not, but I know like the medical centre they send you text reminders that you need to come in and ... so it's a bit hard to sort of repetitively say no."*

*Zoe: "If you were like constantly going to your doctor and you hadn't got it, I feel like they would keep getting at you and be like oh you need to have your cervical smear... they would definitely try and talk you round at least at first."*

*Lily: "I feel like my doctor now would probably put some pressure on... my doctor would probably try to convince me..."*

*Isabella: "I wouldn't feel very comfortable telling [the doctors I didn't want to come], I might have to make sure I did a lot of research about it first, to make sure that I could*

*argue my points to why I wasn't gonna get one done... I'd be much more comfortable just disappearing or ringing up at home and cancelling you know something like that."*

Some participants believed they would face censure if they chose not to participate. This ranged from experiencing a sense of disapproval, to being insulted by others. Participants joked about being forced to take part in screening.

*Sophie: "I think if you did repetitively turn down getting smears, you could probably like... almost face negative stigma like people would like look down at you for not doing it... For example my mum's reaction would probably be like nah you're being stupid like you have to do it you know..."*

*Olivia: "Aw they'd tell me I was an idiot [if I stopped going]"*

*Isabella: "Umm definitely my mum would tell me I was being an idiot and kick my butt into going, yeah it wouldn't be an option, it would just be 'what do you think you're doing?'... there's never an option of me not going."*

*Mia: "I know that my partner would march me there and make me get it."*

The possibility of not taking part in screening was described as something they might hide from others, and be secretive about. That it would be met by disapproval by others meant that not taking part would be something that had to be hidden to avoid censure.

*Isabella: "I guess I could stop going by myself but not tell anybody, it's not like mum checks at that time of the year that I've gone."*

*Zoe: "It also is expected... um not only in society but also in my family, so I wouldn't really wanna admit, if I say wasn't going, there's no way I would admit it to most people because they'd just be like what?... It'd be like a secret or something you're getting away with, and something you didn't tell people and you'd – I'd probably if it did ever come up I'd be like keeping quiet about it."*

*Lily: "I feel like it's [not taking part in screening] a choice I could make but it's probably a choice I'd be like embarrassed about."*

As well as during their accounts of cervical screening, participants who described being offered HPV vaccinations also shared experiences of obligation and lack of choice during this health procedure. Being offered or receiving the HPV vaccination was for many participants the first time they became aware of what cervical screening was, where it was introduced to

them in the context of a health procedure over which they had little say. Those who remembered being offered the HPV vaccination largely remembered their parents making the decision for them.

*Abigail: "I just got it [HPV vaccination] because it was like you should get it and then my parents were like yeah you should."*

*Isabella: "It was definitely mum and dad's decision, it wasn't like have a talk about it with your parents and decide what is best for you."*

*Mia: "It's definitely not something that... I've ever had a conversation with my mother with she signed a consent form and I did it just cos it just seemed like the thing you were meant to do."*

The experience of being offered the HPV vaccination can be framed as participants' first introduction into cervical cancer and the tools that are used to prevent it. It is important to consider how the initial introduction to cervical cancer prevention, as a school-based programme where young women followed the instructions of their parents, may have impacted on their autonomy when it comes to further cervical cancer prevention, such as screening.

Previous research into cervical screening has described social discourses which create an obligation to take part in screening, where individuals face criticism, stigma and marginalisation if they do not comply (Howson, 1999; Mckie, 1995). The participants in the present study described fear of being censured and stigmatised if they chose not to take part, and how medical professionals, as well as family members and partners would police their behaviour. They also reflected on HPV vaccination as something they did not feel they had a say in, but a time where they had to follow their parents' instructions. This builds upon and extends medical discourse which constructs screening as routine, as screening becomes something women have to do to gain the approval of others, as the only acceptable course of action. The faith and trust held for the medical profession is deeply embedded, and creates an expectation that people will follow medical instructions. For participants, a decision to decline screening would be a thing to be hidden and kept secret. When it comes to cervical screening, choice does not matter, and women instead feel

obliged to comply, or hide a decision to not take part from others lest they be mocked or forced to conform.

This social discourse of obligation again draws upon discourses of femininity, and what it means to be a woman. Within this discourse, women are framed as docile and obedient, complying with the instructions of medical professionals (Gunn & Douglas Varus, 2010). To refuse to obey prescribed and expected behaviours would be a transgression, and participants would face disapproval from their family, friends and medical professionals. Through this discourse, women are disempowered, and transformed into passive objects who have things done to them, rather than being active agents determining their own health and having control over their bodies.

Power is exerted over these women through these dominant discourses of medical orthodoxy and femininity, limiting their ways to act and creating docile bodies. If they were to resist the prescribed actions, they would be marginalised, facing disapproval at best, and coercion at worst, for taking an alternative action. Discourses of femininity and medical discourse are woven together to control women's bodies, subjecting them to surveillance through cervical screening. The restrictions put upon them by family, partners, friends, medical professionals and themselves function to frame cervical screening not just as something women can or even should participate in, but instead as something they have to participate in.

#### *Drawing upon discourses of choice*

In the present study, all participants did take part in cervical screening, and described their decision to take part in different ways. Some emphasised the free and autonomous choice they made to take part; some participated without thinking too deeply about why, instead framing screening as a routine part of being a woman; and others reflected an obligation put upon them to take part. Many of these women described feeling each of these ways towards cervical screening at different points in their interview, contradicting themselves at times. Which way of framing cervical screening was used depended on the function that particular construction of cervical screening held at that point, and was used to position themselves positively and make sense of the way they navigated the world.

Participants did not for the most part acknowledge the multiple, contradictory ways in which cervical screening was framed by them, although some did mention that the differing ways they spoke about cervical screening seemed incompatible. Zoe in particular reflected on the conflicting views she held,

*"[Cervical screening] is expected... not only in society but also in my family, so I wouldn't really wanna admit, if I say wasn't going, there's no way I would admit it to most people because they'd just be like what? But then again I wouldn't decide not to, like it is still something I would wanna do so, sort of like I wanna do it, but I also see that I wouldn't really feel like I had much of a choice...*

*I decide yup this is what I think, but then again it's also exactly what my family and my parents think, so you never really know if it's your decision or if it's influenced by them cos it's not different, and we all know how influenced we are by what everyone around us thinks."*

For other participants, the contradictions in their talk, from describing ways they would keep secret or be embarrassed about not taking part in screening, to the positive ways they felt about screening and how it was something they chose for themselves, was not explicitly realised. For several of the participants, the acknowledgement that they would feel uncomfortable or unable to decline screening was of low importance, as it was something they would never need to deal with since they chose to take part freely.

Participants drew upon different and conflicting discourses as they talked about choice in relation to cervical screening. They positioned themselves as autonomous, informed, health consumers who freely made smart choices that protected their own health. This parallels ideas of the patient as a consumer in a medical encounter, drawing upon an empowerment discourse. McDonald et al. (2007) described how within this discourse, health is a commodity, and as consumers, individuals make the decisions about their health. This is demonstrated through the way participants described the positive feelings they had towards cervical screening as something they chose to protect their own health. At the same time, participants did not question the dogma of the medical system that they were surrounded by, and adopted the prescribed medical practices as recommended, making them part of the routine responsibilities placed upon them. This reflects faith held in medical orthodoxy, and the influence of dominant medical discourse, as well as the need to



be obedient to medical professionals' instructions as part of a femininity discourse. There is a need to consider how the power imbalance in a medical encounter interacts with medical ideology to influence the interaction and decisions made by the patient. Waitzkin (1989) described how medical encounters may be used to reinforce dominant ideologies and social order. When a medical professional, who is in a position of power over a patient, expresses medical ideology it may be difficult for a patient to resist the ideas and recommendations of the medical professional, and instead these ideas are likely to be accepted and may become internalised.

In the present study, participants accepted the recommendations of medical professionals without questioning it, framing it as a routine part of health maintenance. And while positioned as autonomous agents, participants at the same time did not feel able to decline screening or make a choice that conflicted with what their doctors, nurses, partners, friends and families saw as the responsible course of action. This reflects the power imbalances between medical professional and patient in the medical encounter, and how patients can be disempowered through this interaction which exerts medical power over them, and become unable to dissent or take an alternative course of action. Medicine has been described as a form of biopolitical regulation, which subjects bodies to governance (Gunn & Douglas Varus, 2010). This regulation is experienced over an extended period of time through medical encounters, mainstream media and everyday interactions which draw upon dominant medical discourses, and may become internalised, so that processes of surveillance and discipline are undertaken by individuals themselves, and their peers, as well as by the medical profession. A woman's entire social world may play a role in the regulation of her body, through ideas of good and bad health practices and behaviours, which stem from medical ideology but are communicated by multiple sources. For the participants in the present study, the drive to participate in screening comes not just from doctors, nurses, other health professionals, and health messaging; but also from their partners, families and friends, creating a coercive experience.

The New Zealand health system is framed as being based on a system of patient autonomy, where individuals are free to make an informed decision to decline any treatment or procedure, and with health policy reflecting a patient-centred model (HDC Code of Health and Disability Services Consumers' Rights Regulation 1996; Kaba & Sooriakumaran, 2007;

Robb & Seddon, 2006). However, at the same time, health targets and medical orthodoxy can place pressure on people to comply with the instructions of medical professionals, whether or not they understand the rationale for doing so. The patient-centred approach emphasises fully informed decision making, but the options and choices available to patients are presented through an official discourse, motivated to encourage participation in prescribed health practices, and the information available and dominant discourses are likely to be skewed in favour of this. While medical discourse may have moved on somewhat from that described by Foucault, demanding that people surrender ownership and control of their bodies to the medical professional (Foucault, 1991), echoes of this can still be seen in current dominant medical discourses which continue to position medical professionals as experts and patients as passive (Lupton, 2012), with the function of encouraging people to respect and follow their instructions. While there is a current emphasis on providing patients with information and engaging them in decision-making processes (Kaba & Sooriakumaran, 2007), the power imbalance that is perpetuated by this expert medical professional-passive patient positioning means the medical encounter is still likely to follow a doctor-knows-best rhetoric, unless actively challenged by empowered patients and enlightened medical professionals.

Discourses of femininity which position women as vulnerable and weak, susceptible to ills of the mind and body have been seen throughout history (Shuttleworth, 1990; Turner, 2008), but it is important to examine how modern discourses of femininity function in the context of cervical screening. Bush (2000) explored how medicine controls women's bodies and is used to construct femininity. Medical control and discourses of femininity limit ways of acting, and frame participating in screening as the correct way of acting, so that those who do not participate are positioned as deviant and a threat to the success of cervical screening in preventing cervical cancer. The way women's bodies are controlled functions to reduce bodily autonomy, limiting their ability to be active agents of their health and bodies, and transforming them into passive objects.

The courses of action available to women when it comes to cervical screening become limited through the reinforcement of dominant discourses which position medical professionals as all-knowing experts, and women as docile, passive patients. Discourses of empowerment and patient autonomy, which could be used to resist and challenge the

dominant discourses, are instead adapted to fit in with them. Being an empowered, smart health consumer means making fully informed health decisions, but only as long as they align with what the health system dictates, listening to the wisdom of medical professionals and obeying their recommendations. For the participants in the present study, while they made autonomous choices for themselves, the choices available to them are limited through dominating and marginalised discourses. Some actions are legitimised by dominant discourses, such as the choice to participate in screening, which seems desirable being based on the recommendations of expert medical professionals, while others are marginalised, such as not participating in screening seeming foolish and disobedient, inconsistent with how they view themselves as smart health consumers. The options available are thus limited, reducing their capacity for choice.

For individuals and especially women, it is important to critically examine how we make decisions, as we see ourselves as making decisions freely, yet at the same time these decisions often align directly with what we are told to do, and making an alternative decision may be met with disapproval and censure. While our subjective experience is that of having control over our own bodies, dominant discourses constrain what courses of action are available to us, and alternatives are marginalised or made invisible. Women are not simply invited to take part in cervical screening, they are coerced.

### **Morality**

Participants' talk about cervical screening introduced a dimension of morality to the subject. This included an individual responsibility to protect one's own health, a social responsibility to protect others' health, and ideas around becoming sexually active and its link to morality. Each of these three ways morality was implicated will be considered, and then the ways in which participants drew upon them explored.

#### *Individual responsibility*

Some of the participants described feeling that they were being responsible in participating in cervical screening to prevent cervical cancer, and reflected that they might feel guilty if they

didn't take part in screening. They positioned themselves as responsible for preventing cervical cancer in themselves.

Abigail: *"If you get into trouble... it's your health so if you didn't do it, it's only gonna get more invasive."*

Lily: *"If I didn't go and then I did get cervical cancer I'd feel so guilty."*

When considering those who chose not to take part in screening, judgements ranged from perceiving them as uneducated, to outright stupid and irresponsible. For the participants, people who did not participate in screening were doing something wrong or foolish.

Sophie: *"I think it's a bit silly... if you just ignore these things and don't get them checked out, you know there's a possibility you could end up dying and well- or like be really really sick."*

Abigail: *"I think ultimately it's their call... but that perhaps they're not as educated as they should be,"*

Olivia: *"I think it's a not clever decision cos it doesn't take very long... I think if you don't go, then you're taking a risk with your health that's unnecessary... people can be stupid."*

Mia: *"It's on par with people who don't, who are you know, diagnosed with diabetes and don't look after themselves... take preventative measures because if you value your life you will, you know look after yourself."*

Participants described not taking part in screening as doing something wrong against themselves, and through this showed that for them, cervical screening was not morally neutral, and instead had a moral component. As Howson (1999) states, health practices such as cervical screening cannot be simply seen as neutral, but instead need to be considered as a "embedded within a moral framework of responsibility and obligation" (p.402). Previous research has demonstrated that compliance with health practices such as cervical screening are constructed as the correct, ideal thing to do (Bush, 2000) and a women's duty (Howson, 1999), while non-compliance is constructed as irresponsible and wrong (Mckie, 1995). This was echoed by the participants in the present study, with their descriptions of the necessity to take part as a responsibility to protect their own health, and the judgement passed on those who did not take part.

The prospective guilt that participants would feel if they got cervical cancer, alongside the judgement passed on those who do not take part in cervical screening, draws upon a neoliberal discourse of individual responsibility (Resnik, 2007). Victim blaming of those who do not take part in screening and become ill means that cervical cancer is not morally neutral, but has a moral dimension. It is something that individuals are responsible for, and have a duty to prevent in themselves. Women are obliged to look after themselves and protect themselves, and for the participants in this study, this was done by complying with cervical screening.

Discourses of femininity are also drawn upon here, as taking part in cervical screening becomes not just part of being a woman, but part of being a "good" woman. Bush (2000) has described how discourses regulate women by constructing femininity and creating docile bodies. Through this construction of femininity, what it means to be a "good" woman is to be obedient. To not comply with medical instructions becomes a transgression, where a woman fails to fulfil her social role and protect her own health. For the participants, not taking part in screening is something to be met with disapproval, and a failure on the part of the individual, not just to be smart but to be "good".

Power and control is exerted over the participants and regulates their behaviour, as the female body is a site of "surveillance and regulation" (Mckie, 1995, p.445). Not only does the medical system exert control over women's bodies, through problematising those who do not take part in screening and using aggressive methods to promote compliance, but this control extends to an individual level, where women police themselves, and through the idea that non-compliance is morally wrong, maintain the power structures that control women's bodies. In the present study, participants demonstrated that cervical screening participation was linked to individual responsibility, where they were responsible for maintaining good health and protecting themselves, internalising dominant medical discourses and discourses of femininity so that medical governance and regulation over women's bodies comes not just from health professionals, but from women themselves.

*Social responsibility*

Talk around social responsibility spanned the duty that an individual had to look after their health for the sake of others, as well as the responsibility individuals felt to encourage others to screen. Participants described the sense of duty they felt, and that others should feel, to comply with cervical screening as part of their social responsibility.

Participants felt that there was a duty to take part in screening, and to protect their health, both for the sake of loved ones, and also as part of being a responsible member of society and avoiding draining the resources of the New Zealand health system.

*Abigail: "[If] they decided to not get a smear which is their choice, but then when they don't pick something up and then they get cancer or whatever then that's us that's paying for it when the rest of us have like taken those steps to prevent it... you're disadvantaging like the whole system by not doing it."*

*Eva: "I think it's probably a good thing to do in just the wider new Zealand society in terms of detecting cervical cancer... if you become sick and you're unable to look after your family or you umm maybe you die from cancer, or the treatment, and it could have been prevented, surely you know you'd feel a bit of a fool."*

Participants described things that they would do to encourage others to take part in screening, and were compelled to promote screening and protect others' health. They expressed a desire to understand why people might not take part, so that they could help persuade them to do so.

*Mia: "I would try to engage in conversation... see if there was anything I could personally do to facilitate them, you know, going through it cos I think it's quite important."*

*Chloe: "If a friend said oh I don't get them I'd probably ask them you know, how come? And like talk to them about why you've made that choice and it's totally fine to make that choice but why? What are your reasons behind it, and I'd probably give them my reasons behind why I do go."*

*Charlotte [works in health]: "I obviously need to screen and practice what I preach... and like share my experience so people might – to encourage people to screen, because so many people don't do it... knowing like the statistics and people's experiences of the health system makes me want to go and have good experiences and do those and tell*

*people about them, so that it will make people screen... if I did have a shit experience, I would still screen, because it's that important, do you know but I probably wouldn't tell people about it, um in that way because I wouldn't want to discourage anyone from doing it."*

It was particularly interesting that several participants offered up ideas of how to encourage people to take part, and initiatives that could be used to get more people to take part, despite the interviewer having purposefully avoided anything around encouraging screening. Participants appeared to hold an underlying assumption that the goal of the research was to find ways to promote cervical screening, and that encouraging participation was a social good they could and wanted to do.

Discourses of femininity have placed health in the domain of women, in that women bear the responsibility for maintaining and protecting the health of their families. In addition to the responsibility to protect their own health, women are tasked with protecting the health of their children and partner too, and may be caring for other relatives as well (Wyn, Ojeda, Ranji, & Salganicoff, 2003). Women may be placed in the role of health promoter for their family in addition to themselves, so that as well caring for unwell members of their family, they are tasked with encouraging family members to take an interest in their own health. Howson (1999) describes that part of a woman's social role is to look after herself, alongside occupying the role of carer and healer, responsible for protecting the health of her family and others. According to Howson, for women this self-responsibility and responsibility to others forms part of what it means to be a good citizen and a responsible member of society. So for participants, the act of getting ill with cervical cancer not only means a failure to do one's duty to protect one's health, but can also mean a failure to protect one's own family if they are no longer able to care for them, and a failure to be a responsible citizen. This also links in with the sense of social responsibility to encourage cervical screening in others that participants experienced. Women as healers are expected to be nurturing and care for others, and this can include protecting the health of friends, family, and even strangers. Other research has noted that women adopt a health promoter role through encouraging others to take part (Bush, 2000), and in the present study this was demonstrated by participants in their earnestness to understand why someone might not screen, and how they might be able to persuade them to do so.

*Sexual activity*

Morality as it related to sexual activity was also explored. Participants varied in whether they explicitly conceptualised cervical screening as part of sexual health, but for many, they fit screening in with other sexual health practices such as accessing contraception.

Sophie: *"If you get it [at university health services] then it's free cos' it falls under sexual health."*

Isabella: *"I guess I would put it under sexual health care, just because you know I generally fit it so that it's the same time I go and get contraception or go get a swab."*

Lily: *"The reason I had asked for a smear was because I was having pain during sex."*

For some participants, there was a salient link between sexual activity and risk. They reflected on how sexual activity was part of discussions around cervical screening with medical professionals, and how becoming sexually active was linked to becoming at risk of cervical cancer and starting screening.

Abigail: *"When I had to go in for the biopsies they were like are you on the pill... yeah I'm not sure why but they always ask that so."*

Olivia: *"It was more kind of like 'oh you're sexually active... we need to do this'."*

Chloe: *"I feel like it's something that everyone's at risk of but then at the same time I'm kinda like... obviously it's sexually transmitted so it depends on your sexual lifestyle as well."*

Charlotte: *"Being like... 'have you had sex? Yes? Okay you need to do this', it's very much like, oh you did a bad thing, do you know what I mean?"*

Some of the participants described feeling less at risk because they did not have multiple sexual partners. They felt cervical cancer was less likely to affect them because of the choices they made about sexual behaviour.

Eva: *"I've only been with one partner at the moment... but I'm assuming the more people you sleep with or have sexual contact with, the higher your chance..."*

Chloe: *"I mean I'm in a relationship now and have been for [several] years... so in terms of, you know, being at risk of it now I feel like that risk is lower."*



Most of the participants did not describe any moral conflicts or sense of anything wrong with sexual activity being related to cervical cancer, but the salience of the link could have a different impact on women who were less sex-positive. This was reflected by some of the participants.

*Zoe: "I remember being sort of around 16... and just being a bit like worried that I might have already needed one but I was too scared to go and get one, cos I didn't want to admit that I was having sex... [I] wasn't really ready to be having sex so then wasn't ready for the consequences of smears and contraception."*

*Charlotte: "People that are like embarrassed that they've had sex, or perhaps were assaulted or... umm did something that they were ashamed of, that sort of thing... like if you just had sex last week and your parents don't know and you're like, you're very ashamed about it and your doctor says are you sexually active? Oh you should get this thing. It would be like really bad I can imagine."*

As part of discussion around sexual activity and risk, HPV was explored by participants in the context of its role in the link between sexual activity and risk of cervical cancer. Several participants had very little knowledge around HPV, but for some, its transference through sexual activity was an important aspect.

*Zoe: "I remember being really disturbed when my dad was saying sort of like well most, if you've come in contact with, if you've had sex then you've like, if you've been sexually active for a s- amount of time then you've almost definitely come into contact with genital warts."*

*Charlotte: "It does like um... feel like an STD to me because like that's kinda what it is but also it doesn't feel like, have the stigma of an STD?"*

The relationship between sexual activity, HPV, cervical screening and cervical cancer creates issues for women around morality. The involvement of sexuality implicates morality in cervical screening, as the procedure examines the vagina, a site for sexual activity, and as questions about sexual history may bring forth issues about "right" and "wrong" behaviour. Discourses of femininity are used to frame sexual activity and women's sexualities as a moral issue (Montemurro, Bartasavich, & Wintermute, 2015). Within discourses of femininity, the "good" woman is traditionally passive and chaste, and, while expected to fulfil the "needs" of a husband when married, her own sexual desire is invisible (Gavey,

2005). Any expression of sexuality that falls outside what is morally accepted is deemed dangerous and threatening to society's moral fabric (Jacobus, 1990). While the boundaries of acceptable and unacceptable sexual behaviour may have moved, with research describing increased acceptance of casual sex (Farvid & Braun, 2014), it is still important to acknowledge that sexual behaviour and desire plays an important role in shaping an individual's identity, and is bound by the cultural norms of the social world they live in. Hence women are caught in a web of morality as they participate in cervical screening, having their sexual behaviour examined in the context of a health procedure, as behaviours that are deemed "wrong" are used to frame a woman as "good" or "bad".

Cervical screening places a woman's sexual history and behaviour under surveillance, and can lead to women being blamed, or blaming themselves, for cervical cancer and attributing it to being promiscuous. There are certain types of sexual activity which are seen as more acceptable than others, and while sexual activity in itself may be less subject to moral sanction, a "very high" number of sexual partners, not using contraception or becoming sexually active at a young age may still be considered as a transgression (Farvid & Braun, 2014; Mckie, 1995). These behaviours may be asked about by a doctor or nurse as part of establishing risk, but at the same time can subject the patient to scrutiny, shame and stigma. Even if women are accepting of their sexual experiences and identity, the process of discussing it with a medical professional in the context of risk can implicate the dimension of morality, and bring up a consideration of socially acceptable and unacceptable sexualities.

Women's sexuality is policed through the act of participating in cervical screening, and sharing sexual history with a medical professional. So long as a woman is the right age, and engaging in what is considered "good" sexual activity, then starting cervical screening can be framed as part of becoming a woman, free from moral judgement. But if a woman engages in any sexual behaviours that are deemed socially or culturally "wrong", they are shamed as they take part in a health act that they are morally obliged to participate in, and held responsible for how expressing their sexual desires increases their risk of cervical cancer. For women, the understanding that the act of becoming sexually active places them at risk of cervical cancer makes cervical cancer a moral issue.

*Drawing upon discourses of morality*

Health is something that is often considered to be morally neutral, but in action, it becomes something that is value-laden. Being healthy is linked to being a morally good person, while illness and disease are linked to a lack of morals (Crossley, 2001). Individuals are tasked with a moral impetus to attain good health, and may be sanctioned if they fail to do this. This spans several dimensions, that of individual responsibility, social responsibility, and policing of women's sexuality.

Within a neoliberal discourse, dominant in New Zealand, individuals are held responsible for their own health, and part of being a good citizen means attaining health (Crossley, 2001; Resnik, 2007). Lupton (2012) highlights how cancer in particular can be seen as a moral issue, as those who develop cancer often blame themselves for not taking precautions to minimise their risk or prevent it. In a neoliberal society, we are all assumed to be capable of achieving good health if we try hard enough, and health is a commodity which people are morally obliged to work towards (Crossley, 2001; Mielewczyk & Willig, 2007). As part of this, if someone is unhealthy, they are bad or weak, and may be met with sanction. The less extreme version of this neoliberal assertion pities those who do not look after their health, viewing them as ignorant or incompetent, in need of educating (Resnik, 2007). This discourse can be seen permeating through public health policy, which emphasises behaviour change and ignores social context in shaping health. Rather than focusing on how factors such as gender, class, sexuality, culture, and ability influence health and illness, there is a tendency in health research and policy to focus on health as a goal which individuals ought to seek to attain, and health is constructed as within the control of each individual (Jones, 1994; Mielewczyk & Willig, 2007). If someone falls ill, they often look at what they did wrong, and how they could have prevented it. The participants in the present study drew upon this neoliberal discourse of individual responsibility, describing the individual guilt they would feel if they fell ill, the moral obligation to take part and protect their health, and passing judgement on people who do not take part in cervical screening. Victim-blaming is a core part of this discourse, where if someone were to develop cervical cancer who did not take part in cervical screening, it would be their own fault. Crawford (1977) described a victim-blaming ideology in health, which places the responsibility for health on an individual to change their behaviour. Victim-blaming may be seen through policies that punish or

marginalise people for being unhealthy, such as economic sanctions or education initiatives to change behaviour. Victim-blaming may be used as a tool, rooted in neoliberal ideology, for diverting attention away from the social causes of ill-health. Participants draw upon this as they describe the importance of understanding and educating those who do not take part in cervical screening, in order to change their behaviour. They considered to a limited extent the impact of cultural factors on cervical screening behaviour, but still with the overarching goal of increasing screening participation. Through this discourse of individual responsibility, health is framed as something that everyone can and ought to achieve.

For women, responsibility for health does not end with themselves. Women are responsible for our own health so that we can take care of our families, as well for protecting the health of others, and being a good citizen means protecting each other. Turner (2008) described regulation of the health and body as a process of social order. Through this process, the body becomes a social object, playing a role in maintaining patterns of behaviour and being in society. This makes the health of an individual a problem for wider society, encouraging surveillance and regulation of people's health as a social good (Howson, 2004). The way in which the majority of research into cervical screening has focused on barriers to screening, and how to promote participation (Foliaki & Matheson, 2015; Jameson, Sligo, & Comrie, 1999; Lovell, Kearns, & Friesen, 2007), demonstrates the way in which cervical screening can be framed as a social issue. By positioning cervical screening as a desirable behaviour, it becomes a goal for this type of research to change women's behaviours and increase participation as a way of doing social good. Through this, researchers too take on the role of regulating the body. As cervical screening is framed as a desirable behaviour which members of society are bound to promote, cervical screening is transformed into a moral issue, where researchers, medical professionals, and individuals take on the task of encouraging participation as a social responsibility.

There is particular social responsibility placed upon women to protect the health of others, through caring and healing for them (Lupton, 2012). Women in the role of healers become responsible for protecting other's health, and not solely their family. This social responsibility extends to encouraging anyone who does not take part in screening to participate. Previous research has described how women encourage or are encouraged by their friends and family to take part in cervical screening (Howson, 1999), but in the present

study there was a concern by participants at the thought of anyone hypothetically not taking part, and a desire expressed to understand the reasons for not participating to try to change it. The social responsibility to protect others' health was not limited to those within one's social group, but extended to protect the health of all women.

A social responsibility to prevent cervical cancer is drawn upon by participants both to encourage screening in others, and to frame their own participation as being socially responsible. Participants in the present study described their role in staying healthy and taking part in cervical screening within a context of social good, avoiding draining resources by falling ill from a disease that is framed as preventable by official messaging (Ministry of Health, 2014a). Rose (1990) locates an individual person's drive to protect and pursue good health in themselves as part of social obligation. Through this, good health forms an aspect of being a good citizen and a member of society. Lupton (2012) describes the act of falling ill as removing someone from their family and social responsibilities and obligations. There are additional implications for women if they fall ill, as they may be the primary caregivers within their family, and so by being removed from their social responsibilities the entire family is negatively impacted. Falling ill, especially from something framed as preventable, thus may be a more extreme moral failure for women than men as there is a greater impact on others if they are removed from social obligations.

Cervical screening becomes a moral issue of individual and social responsibility through the discourses that construct it. At the same time, the ways in which sexuality is implicated in cervical screening also links to morality.

That sexual behaviour is implicated in risk of cervical cancer forges a further link to morality. As sexual activity is necessary for becoming infected with HPV, the virus that is implicated in most cases of cervical cancer (The New Zealand HPV Project, n.d), cervical screening may involve questions and consideration of sexual behaviour, as medical professionals explore how sexual behaviours may have affected someone's risk of cervical cancer. Through this process, sexual behaviour is surveilled and policed by medical professionals, and may become internalised by women themselves.

Through the mechanism linking sexual activity and cervical cancer, having sex can be framed as an act which opens oneself up to disease and danger. By engaging in sexual activity,

women become at risk of cervical cancer, and within a neoliberal discourse individuals are capable of, and morally responsible for preventing themselves from falling ill (Resnik, 2007). The biological mechanism linking sexual activity and cervical cancer is such that the majority of sexually active people will be infected with HPV at some point in their lives, and only a very small number of these people will go on to develop cervical or other cancer as a result (The New Zealand HPV Project, n.d). Despite this almost inevitability of HPV infection, that the mechanism implicates sexual behaviour in cervical cancer still brings a moral dimension in to cervical screening as sexual behaviour becomes a risk factor for cervical cancer, and cervical screening provides an opportunity to surveil sexual behaviour. The process of cervical screening and the interaction with a medical professional may include a discussion about sexual behaviour and how someone's sexual behaviour has placed them at risk.

Women's sexualities are bound and constrained by social regulation, and the limits of what is acceptable behaviour changes over time (Howson, 2004; Turner, 2008). Women's bodies may be constructed as sexualised and valued for their sexual appeal (Duschinsky, 2013), or more extremely as sexual objects or commodities used to advertise and sell products (Howson, 2004). Alternatively, women's bodies may be constructed as vulnerable, with a responsibility placed on "good" citizens, male and female, to protect women's bodies from threatening sexualisation or objectification (Duschinsky, 2013; Gavey, 2005). These alternative constructions create different possible identities for women, which they are pressured to adopt in different contexts (Montemurro, Bartasavich, & Wintermute, 2015). While women's own sexual desires may be invisible (Gavey, 2005), they are on different occasions expected to be sexually desirable or control their sexual behaviours to fit boundaries of what is considered moral. This can mean that by engaging in sexual behaviours that fall outside the realm of what is "good", women are faced with shame and stigma for expressing their sexuality.

Different aspects of culture, religious beliefs, class and so on may influence the extent to which a lens of morality is placed over sexual desires and behaviours. In the present study, all participants expressed a connection either with New Zealand culture, or did not see themselves as having a culture; none expressed a religious affiliation; and many described open, sex-positive upbringings. These cultural and social experiences frame the construction of sexuality in specific ways, with differences in how it shapes women's identities. Women

may draw upon “good” or “bad” sexual behaviour to position themselves as “good” or “bad”, and for the women in the present study sexual behaviour was not drawn upon to position themselves as bad. However, the way in which sex functions as a risk factor for cervical cancer was still drawn upon by participants in similar ways, in that by becoming sexually active one also becomes at risk of cervical cancer, and by being more or less promiscuous the risk is increased or decreased. Bush (2000) notes that there is no equivalent screening test or medical procedure which places men’s sexual behaviour under surveillance, and this highlights how cervical screening can be used to surveil and police women’s sexuality and sexual behaviour, as well as making them morally responsible if they do fall ill and have engaged in sexual behaviours which are seen as unacceptable.

Illness and disease are framed in different ways depending on whether lifestyle and behaviour has played a role in falling ill, and those who fall ill may be blamed if a different behaviour might have prevented or reduced their risk of illness (Morone, 1997). With cervical cancer, engaging in sexual activity places individuals at risk, and this may be more or less salient depending on whether a particular sexual behaviour is seen as more risky or “wrong”. For the women in the present study, because of their sex-positive and fairly liberal perspectives on sexual behaviour and desire, the boundaries of acceptable sexual behaviour may be broader than those who engage with different discourses with more restrictive ideas of sexuality, but at the same time the process of a sexual transgression being a moral issue and blaming women for developing cervical cancer is still present.

It is worth considering how the physical experience of cervical screening, being a gynaecological examination which involves examining the vagina, may implicate issues of morality. That the vagina is a part of the body that is often framed solely as a sexual site (Duschinsky, 2013) may make cervical screening as a procedure a moral issue. Existing research has explored how the vagina, framed as a site for sexual activity, is implicated in women’s understandings and feelings around cervical screening. Research into barriers of screening reports that for some women, the vagina being seen as a zone only for sexual intimacy or for one’s own partner can act as a barrier to participating in cervical screening (Foliaki & Matheson, 2015; Jameson, Sligo, & Comrie, 1999; Lovell, Kearns, & Friesen, 2007). Allowing a medical professional access to the vagina is constructed as “wrong”, but at the same time there is a moral impetus to participate in screening to protect ones health. This



creates difficulties for women who are morally bound to participate in screening, but are confronted with a sense of it being “wrong” as they do. The research which has identified the sexual dimension of cervical screening as a barrier, constructs it as something to be overcome, rather than questioning the ways in which women’s sexuality is scrutinised and policed, and transformed into a moral issue, and how this could be challenged.

Lupton (2012) stated that morality intrudes on issues of illness if someone is perceived to have brought it on themselves, especially through risky lifestyle behaviours, and if someone fails to follow medical professionals’ instructions. This has been seen with health problems that arise as a result of smoking and drinking, and is also seen here with cervical screening. For individuals who fall ill with cervical cancer, morality is implicated in terms of whether they have fulfilled their individual and social responsibility to take part in screening as advised by medical professionals, and whether they have engaged in sexual behaviour that is considered to put them at risk. By focusing on how an individual may have prevented cervical cancer, victim-blaming occurs which makes people culpable if they fall ill, and cervical screening is transformed into a practice which people are morally obliged to participate in.

### **Vulnerability**

Vulnerability was present in participants’ talk as they described the ways in which they experienced feelings of vulnerability in relation to cervical screening. They described this sensation in several ways: in the context of their own vulnerability to cervical cancer; the protection that cervical screening was perceived to offer; and through feelings of vulnerability about the experience of undergoing screening. Each of these three ways will be described in turn, and then the ways in which participants drew upon discourses of vulnerability will be explored.

#### *Vulnerability to cervical cancer*

Participants reflected on their own perceived vulnerability to cervical cancer, and many of them did not consider themselves particularly vulnerable. Several of them felt that their age and family history meant they were of low risk.



Eva: *"The funny thing is I'm never nervous about hearing the results, I kind of forget that I've had it so I can't be too worried about cervical cancer really."*

Mia: *"I'm quite young so the chances are quite low... I don't think you really think about it when you're young... at this stage in my life, I think I'm quite separated from the idea of cancer, if that makes sense, just feel like I'm still young and I have other problems that'll hit me before cancer."*

Chloe: *"[abnormal results] can be of concern initially but it's not really anything to worry about really... I've never really thought of cervical cancer that much cos it's never really been anywhere... I don't know anyone that's had it, so it's never really been anything I've needed to think about as such."*

Charlotte: *"I don't have any risk factors that I know of, um... and I've had my [HPV vaccinations] too."*

Others discussed how sexual behaviour and becoming sexually activated was implicated in their vulnerability.

Eva: *"I've only been with one partner at the moment... but I'm assuming the more people you sleep with or have sexual contact with, the higher your chance... if you're not sexually active... you're not obviously not at risk."*

Charlotte: *"Oh someone's been in there we need to check after now that that's happened... like 'have you had sex? Yes? Okay you need to do this', it's very much like... 'oh now you've done that, we fucking need to check you'."*

Abnormal smears were also important in confronting participants with feelings of vulnerability. They described the surprise of an abnormal result, having not previously considered the possibility of it.

Olivia: *"I'm just supposed to do this every two years and nothing's supposed to happen, what is this? Just cos yeah cos every, each time I'd get a letter saying normal result normal result, and then you get a phone call saying not normal result I'm just like, no that's not what I signed up for no."*

Isabella: [when a friend got an abnormal result] *"I thought that oh shit abnormal you definitely you know there's something wrong there's precancerous or cancer you know like I was really worried and stuff."*

Lily: “[doctor] referred me to a gynaecologist ... I was like oh my god I didn’t really know what it meant, and then when I got a referral letter in the mail... it said it was like to take a biopsy to test for like cervical cancer cells and I was like what the hell.”

Chloe: “When ones pop up that are kind of like slightly abnormal change... in the back of your mind you’re still a little bit like mmm what if? ... you hear all these stories about cervical cancer and you’re kind of like ah I’ve got cervical cancer... sits in the back of your mind.”

Messaging from medical professionals played a role in participants’ perceived vulnerability.

Sophie: “[the doctors] were like oh you should come in for your next smear... um the nurse said we’re so delayed and booked up that don’t even bother making an appointment for another three weeks... it made me think about the professionals’ opinion in it... [if] they found it like an unnecessary task.”

Abigail: “It did really freak me out going to hear [one doctor] say... you need to get it done within a few months ... and then [another doctor say] ‘no, no, it’s fine, you don’t have to worry about it’ and it was just the conflicting information.”

While fear of getting cervical cancer has been reported in other research as playing an important role in screening behaviour (Bush, 2000), in the present research, participants did not express much fear about cervical cancer. They drew upon a medical discourse that positioned medical professionals as powerful and knowledgeable, capable of ensuring they did not get cervical cancer. Participants abstractly described that they did not want to get cervical cancer, but had such confidence in the effectiveness of cervical screening that it did not seem like a possibility for them, so long as they took part in regular cervical screening.

For some participants, the experience of getting an abnormal smear conflicted directly with this notion, confronting them with the possibility of cervical cancer, despite them complying with medical professionals’ instructions. This experience provides a possible space where dominant medical discourse, which positions medical professionals as all-knowing and all-powerful, may be challenged. For the participants however, there was little resistance or challenging of dominant discourse. Instead, participants reassured themselves that by detecting abnormal changes early, they were protected from cervical cancer. For these women, being confronted with the fear of cervical cancer further reinforced their desire to participate in cervical screening and be safe from cervical cancer, consistent with other

research where abnormal results made cervical screening more important for women to protect themselves and others (Bush, 2000).

### *Protection through cervical screening*

Protection from vulnerability through screening focused on having trust in the medical profession. Participants expressed feelings that doctors and nurses could be relied upon to protect their health.

Sophie: *"I mean it protects people like myself, who's going into these things that we have more knowledge of what is happening."*

Eva: *"I really respect the medical profession, as long as their attitude towards it was professional and they told me what they were doing... you can only know what you know from medical advice."*

Zoe: *"I mean it is sort of their job to you know protect us from these things and like warn us about the health risks."*

Chloe: *"[results] pop up that are kind of like slightly abnormal changes and the doctors reassure you that it doesn't really mean anything and it's not a problem, they're just gonna check it out just in case."*

Faith in the effectiveness of screening was also mentioned by participants. They felt that screening was an effective tool for preventing cervical cancer.

Sophie: *"It's a good thing doing the smears because it's a like a preventative thing, so you can do something about your future and avoid the possibility of cancer arising."*

Olivia: *"If it is... something then there's a good chance that they will have picked it up early enough to it just needs to be a quick operation and it'll be fine."*

Zoe: *"I [thought] oh it'd be cool – it'd be good if you could just get everything checked and then you wouldn't, you wouldn't have any kind of worry that there might be something there."*

Lily: *"I feel safe that I won't get cervical cancer if I get smear tests."*

Participants also talked about the perceived protection offered by HPV vaccinations as part of reducing their vulnerability to cervical cancer. Many of them had, when offered the HPV vaccination, believed it would stop them from getting cervical cancer.

*Abigail: "I had like the three injections for it... but then I still had abnormal smears and stuff, so it either didn't work or it's not what they said it was."*

*Isabella: "I know that you get it because it can reduce or prevent cervical cancer."*

*Zoe: "I remember thinking oh well if I've had the vaccine maybe I don't need to get smears."*

When participants described their feeling safe and protected from cervical cancer through cervical screening and HPV vaccination, they drew again upon medical discourse. As patients, they were positioned as submissive, relying on the knowledge of doctors and nurses to protect them as they followed medical advice. This produces a power dynamic where women, who are constructed as vulnerable, release autonomy over their bodies and into the hands of medical professionals. Fear and an awareness of one's mortality can make the only course of action available to women be to participate in cervical screening. Absolute confidence and trust in the medical profession draws upon mainstream discourses which position doctors as "benevolent, knowledgeable... with almost mystical powers" (Lupton, 2012, p.54). Official discourses and messaging around cervical screening are drawn upon, as participants reflected the trust they held for medical knowledge, and how their choice to take part was heavily linked to their ability to protect them from the danger of cervical cancer.

#### *Vulnerability as part of cervical screening experience*

Allowing oneself to be surveilled as part of screening, and the vulnerability that comes alongside it, was talked about by participants. They described the physical experience and discomfort of screening.

*Olivia: "[my first smear was] invasive and not fun and not what I was expecting cos at the time I think it was my time of the month as well... that feeling of... yeah you should not be here ... you can feel them scraping your insides."*

Mia: *"It was very invasive... I actually felt physical pain, I don't know if that's normal... and I felt like I was in pain for about a week... too close for comfort sort of thing."*

Zoe: *"I remember that it was, gross, in terms of like it was kind of messy... I felt really uncomfortable the whole time... I thought it was actually painful."*

Chloe: *"I'm kinda like 'ooh someone's going down there' you know and... it does feel invasive but obviously it's completely consensual and it's a medical procedure."*

Participants also discussed the psychological discomfort and vulnerability specifically as it related to cervical screening being a vaginal examination. Several of them felt that it is a sacred space usually reserved for a romantic partner or for sexual pleasure, a very private area.

Olivia: *"I know they're a doctor and all but... it's kind of like that sexual taboo thing like if a guy's down there it's for a particular reason... I didn't feel comfortable at all."*

Eva: *"I think anytime you go for any kind of vaginal examination you're always a bit worried about like... am I clean? Do I smell okay? All those sort of weird worries, does my vagina look normal?"*

Zoe: *"It's just a very vulnerable position and it's like it's not someone you know um like if it's a partner or someone you love or like where it's more for fun or whatever then it's like different from that."*

Charlotte: *"It's a pretty sacred place... if you haven't had one before, part of it is like oh someone's going to like see my vagina from like, a real weird perspective, that no one else, I haven't even seen it from that perspective... maybe she's gonna like comment on it like 'ohh yours is weird' you know like it's um and like they have it's real just like a personal – and like they shine light and like literally go in there um... vaginas are very private and very kind of like tapu or something... you don't just show someone your vagina like that."*

The importance of the role of smear taker was discussed by participants, particularly in relation to their gender.

Sophie: *"I specifically asked for a female doctor... because you know it is something that only females can experience, so I thought that a female doctor would be more empathetic of the situation."*

Zoe: *"[It's] important that they make you feel comfortable, I would never want um....a male to do it... the gender is important to me."*

Factors other than gender made a difference in how comfortable participants felt during screening, including their age and manner. They differed in their preference for age of smear taker, but having the procedure explained, and being done in a respectful way was of described many participants as particularly important.

Isabella: *"I had a nice doctor, umm so she was really nice and you know was gentle and told me about what was gonna happen before she actually did it which was nice, I always appreciate that... and told me it was gonna be uncomfortable but that it wouldn't last that long."*

Lily: *"I liked that she was young, and like kind of felt like on my level kind of, not like an old lady or... you know how some doctors are kinda condescending sometimes."*

Chloe: *"I have a doctor that I really like... I'll talk to her about anything and... I can kinda go there with any questions."*

Charlotte: *"I can imagine if they hadn't explained it... would have been like real frightening, so I think that was super helpful that they explained what they were doing."*

The experience of vulnerability, and the ways it could be mitigated, were also reflected in the context of procedures related to cervical screening, such as colposcopy and biopsy. These procedures, which are more invasive than a smear test, involved physical and emotional vulnerability, as the procedure itself was physically uncomfortable and intimate, but were also confronting around concerns about what the test might find and about triggering emotional issues.

Abigail: *"Everyone was really nice and they were like oh you know you can have this person staying in the room with you or they can leave and like we can put it up on the screen... it was a really supportive process."*

Chloe: *"They talk about taking a biopsy, and you'll feel it pinch and I'm like I don't wanna feel it pinch inside my vagina!... it was just like almost crampy which they said was normal... my body was like what are you doing up in here?"*

One participant reflected that a colposcopy was a triggering experience because of its similarity in procedure to a termination of pregnancy that she had undergone, while

another reflected how difficult the smear itself was because of past experiences of abuse. Others reflected on how much more traumatic the experience of having a smear could be for those who had experienced any kind of sexual abuse or violence.

*Chloe: "If they've been sexually assaulted and they're kinda dealing with trauma of that sort of thing then... totally get why you're like apprehensive about that you know."*

*Charlotte: "People that are like embarrassed that they've had sex, or perhaps were assaulted... obviously that's gonna be like not great for like screening."*

The described vulnerability that was experienced as part of the cervical screening experience links in with the power dynamic of a medical encounter. Medical discourse positions medical professionals as experts, in control of the interaction, and patients as passive objects which have treatment done to them, rather than being an active participant in the medical encounter (Lupton, 2012). This creates a context where individuals must release control of their body to another person, someone who has the capacity to exert power over them. For the participants, a key aspect of the cervical screening experience was surrendering control over their bodies to another person, bringing an awareness of their own vulnerability and demanding they trust the medical professional not to use abuse their position of power.

That cervical screening involves an examination of the vagina was described by participants as a major factor in the vulnerability experienced. Mckie (1995) reported discomfort experienced by women when undergoing cervical screening with a male doctor, which she linked to a power imbalance that arose from interactions between males and females being often sexual in nature. For the women in the present study, there was no expressed mistrust or concern that a medical professional would abuse their position of power, however the discomfort and vulnerability at allowing oneself to be intimately examined by a medical professional was discussed in relation the vagina being an area usually reserved for sexual activity. Research into barriers to cervical screening participation has observed similar experiences for women, who identified the vagina as a private or intimate space for sexual activity, and described this as a barrier to participating in cervical screening (Foliaki & Matheson, 2015; Jameson, Sligo, & Comrie, 1999; Lovell, Kearns, & Friesen, 2007). For the women in this study, the sexualisation of the vagina played an important role in shaping

their experience of the process, and they expressed a vulnerability and discomfort as they granted access to their vaginas to someone other than a sexual partner, as well as fears about their bodies being clean and "normal". The intimate nature of cervical screening, and discourses which sexualise women's bodies and at the same time frame them as something which needs to be kept private, mean that participating in cervical screening is an experience which confronts women with a sense of vulnerability.

#### *Drawing upon discourses of vulnerability*

There is a challenge to be faced by women when it comes to cervical cancer. As they experience a vulnerability to or fear of cervical cancer, the course of action to reduce this vulnerability, participating in cervical screening leads to a different vulnerability, as they allow access to their bodies in an invasive procedure. The protection that cervical screening offers them functions to reduce feelings of vulnerability, but there is the potential that they may be confronted with feelings of vulnerability again in the event of an abnormal result.

The vulnerability experienced in the process of cervical screening links in to the ways women's bodies are both sexualised and controlled. Discourses of sexuality construct males as constantly ready and seeking sex, and position women as passive and chaste, responsible for protecting themselves from male sexual advances so as to preserve their virtue (Gavey, 2005), and through this, women are taught to protect their bodies, and keep them private. Women who expose their bodies or behave in ways that are seen as inappropriate may be marginalised or shamed, and Gavey (2005) describes how these women may be held responsible or victim-blamed if they experience sexual violence. At the same time, female bodies are sexualised, particularly through media and advertising (Howson, 2004). Much work has been done on how media constructs women as sexual objects, and the impact of this can be that the female body becomes public property, no longer a woman's own (Wood, 1994). With pornography being increasingly easily available and accessible (Hare, Gahagan, Jackson, & Steenbeek, 2014), many women may be exposed to unrealistic portrayals of what "normal" bodies, and particularly vaginas, should look like. Through being constantly on display for the gaze and approval of others, and being exposed to images of "ideal bodies" in the media, exposing oneself to a medical professional can be a



vulnerable experience. In the present study, participants expressed fears about being sure that they were clean and normal, and about having a medical professional examining them. They reflected that for them, their vaginas were a private space for sexual partners, and there was a vulnerability in exposing them to a medical professional.

The power imbalance between medical professional and patient was also discussed by participants, and several participants reflected that the doctor or nurse talking to them about what was happening, and being supportive, was important in making the cervical screening experience easier. Through doing this, the power imbalance between medical professional and patient was challenged, and by addressing the intimacy of the procedure, the participants were empowered to participate in screening with less of a sense of vulnerability. The vagina is an intimate and private space for many women, and this acknowledgement was an important part of respecting women's bodies. For wahine Māori, this could be particularly important, as *te whare tangata* (the womb) is *tapu*, the place where life comes from, and it is important that this is acknowledged and respected by anyone accessing this space (Le Grice & Braun, 2016).

Fear of or vulnerability to cervical cancer has been described in previous research as a driver for cervical screening participation (Bush, 2000; Whynes, Philips, & Avis, 2007). A particular fear of the body being abnormal or that something might be going wrong inside has been described in other research, and it functions to encourage women to take part in screening to reassure them that there is nothing wrong (Armstrong, 2007). For most of the participants in the present study, there was very little fear or expectation that they would get cervical cancer. For some, cervical screening was seen as important in reducing that vulnerability, but for others they felt so sure that they were not at risk of cervical cancer that cervical screening was constructed as not very important, something they forgot about, and never considered that they would get anything but a normal result. The experience of getting an abnormal result worked to create a sense of vulnerability for those that did experience one, and they reflected that this was unexpected. Previous research has described that an abnormal result can create a sense of vulnerability for women, as well as feelings of concern both for themselves and for others, and encourage them to take part in screening and persuade others to do the same (Howson, 1999). Given that this research was conducted on young women, the risk of cervical cancer may seem very distant, as

something that they do not consider likely to affect them any time soon, and vulnerability to cervical cancer seemed to only become salient when this assumption was challenged through an abnormal result.

The protection that cervical screening was seen to offer played an important role in limiting how vulnerable participants in the present study felt they were. They described a sense of safety, that as long as they regularly took part in screening their health would be protected, both in a general sense of safety in surveillance, and specifically that anything abnormal would be caught and treated early. Other research has explored how the protection cervical screening is considered to provide can be an important tool for reducing fears and feelings of vulnerability (Armstrong, 2007; Bush, 2000). Cervical screening is a tool for gaining information about parts of the body that cannot be observed otherwise, providing women with a sense of reassurance that their bodies are healthy and normal, and participants felt safe that they would not get cervical cancer if they took part in regular screening. Cervical screening may be framed as a form of empowerment for women, increasing control over their body and protecting them from illness. Mckie (1995) described how cervical screening can be framed as a liberation for women in this way, as a tool used to enhance bodily control and prevent cancer's potentially fatal impact. While much of the literature on cervical screening has either uncritically positioned cervical screening as a practice all women should participate in (e.g., Foliaki & Matheson, 2015; Lovell, Kearns, & Friesen, 2007), or more critically as something which social context obligates women to participate in (e.g., Bush, 2000; Howson, 1999), there is a lack of reflection on the ways in which women may choose to participate in cervical screening and frame participation as taking control of their own health. This construction of cervical screening as a form of empowerment is, however, linked to neoliberal discourses, which place individuals as responsible for protecting their health (Resnik, 2007), so that participation is framed as a moral act (Morone, 1997). This means that cervical screening as empowerment cannot be separated from discourses of morality and neoliberalism, and the active choice to participate is inextricably linked to the positioning of oneself as a "good" person who takes responsibility for their health.

Taking control of one's health and participating in cervical screening to be protected from a feeling of vulnerability to cervical cancer, while drawing upon neoliberalism, is also linked to

medical discourse which positions medical professionals as powerful and all-knowing, relying on the knowledge communicated by doctors and nurses to make decisions about health. This reliance on the skills of the medical profession to provide services that will protect one's health taps into a firmly held trust in medical orthodoxy, positions medical professionals as experts on women's health and bodies, and reinforces a medical dominance (Waitzkin, 1989; Willis, 2006). Medical dominance creates an unequal power relationship (Lupton, 2012), wherein a medical professional is placed in a position of power, tasked with the responsibility of determining whether someone is healthy or not, and removing a patient's engagement with and autonomy over their body. Through drawing upon this discourse, people actively hand over the control of their health to another.

While individuals may have chosen to participate in screening as part of taking ownership of their health, this is located within medical discourse and built on knowledge of cervical cancer that originates from the medical profession. Neoliberal and medical discourses may in fact converge to frame cervical screening as an empowering health act which protects individuals from being vulnerable to cervical cancer, but which is built upon a doctor-knows-best framework.

The interaction of neoliberal and medical discourses may also be connected to a discourse of femininity, where women's bodies are constructed as docile and vulnerable to illness (Gunn & Douglas Varus, 2010; Turner, 2008), so that a medical system is needed to take control over their bodies to protect them. While participation in cervical screening may be actively chosen by women, it cannot be separated from notions of feminine vulnerability and reliance on medical power as they actively surrender control of their bodies.

Other research has looked at the way in which cervical screening is used to detect something invisible, before it has any effect on a woman's health, as making cervical screening less meaningful for some women. For example, Bush (2008) shared the account of a woman who questioned why screening is necessary to take part in screening, believing that through a connection with their body women know if they are healthy or ill. This alternative discourse engages with a woman's connection to her own body, but is marginalised by medical discourse which focuses on allowing medical professionals and technologies establish whether someone is healthy or sick. For example, in the case of osteoporosis, research has explored how technology makes an invisible risk condition

visible, which then comes to be embodied and experienced by an individual, when there are otherwise no indications that a person is anything other than healthy (Reventlow, Hvas, & Malterud, 2006). The privileging of this medical discourse over an alternative removes control, knowledge and autonomy of the body from an individual, placing it in the control of medical systems and technologies, and in doing so can be considered to disempower people.

Women become vulnerable to cervical cancer as they reach sexual maturity and engage in sexual activity, and are then encouraged to relinquish their bodily autonomy to medical professionals, relying on their power and knowledge to protect them from cervical cancer. This demonstrates a process by which women gradually lose control over their own bodies, and become vulnerable to medical surveillance and systems instead of to cervical cancer.

### **Choice, morality and vulnerability**

The three webs of discourse identified through this research, choice, morality and vulnerability, are interrelated and function together to construct cervical screening for women. Through choice, women are able to either embrace and own their decision to take part in cervical screening, accept it as part of their routine as a woman, or be obliged to participate by their social world. Morality functions to transform a health issue into a moral issue, whereby individual and social responsibility work to reduce the choices available to women, and where being a woman (and sexually active) becomes a moral issue. Finally, vulnerability works to limit women's choices, making them dependent on the medical system to protect them, and positioning sexuality as dangerous, not just as a moral issue but as a health issue. The webs of discourse work together to construct cervical screening. While choice limits the courses of action available to women, morality transforms non-compliance into a moral issue. Thus the two work together to construct participating in screening as both the desirable and the right thing to do. Choice and vulnerability work together to construct non-participation in screening as dangerous, making it an undesirable course of action. Morality and vulnerability work together to construct cervical cancer as both something to fear, and something to be ashamed of.

Each of these webs, choice, morality and vulnerability, construct and privilege certain ways of understanding and experiencing the world. In isolation, each of them may be critiqued and resisted, but working together they limit the courses of action that are available to women. Through the present research, women can be seen to be navigating the world around them, drawing upon different discourses which function to legitimise their ways of being, and constrain and marginalise alternative ways.

### Conclusion

Constructions of cervical screening were explored in the present study by analysing the discourses that participants drew upon in their talk about experiences of cervical screening. The complexities of understandings and experiences were explored through these discourses, as well as how specific constructions were privileged over others. The findings of the research demonstrate the way in which discourses, through constructing certain realities, function to limit the choices available to people (Phillips & Hardy, 2002). Dominant discourses of health, medicine, femininity, neoliberalism and morality are used to construct cervical screening.

Through this research, cervical screening was located within a social context, making visible the ways that experiences of reality are constrained by social and power relations. The function of various discourses were explored, considering what power structures they relate to, and which groups they privilege or marginalise. Through this analysis, it is possible to challenge these power structures for how they constrain women's experiences and choices around cervical screening.

Participants engaged in autonomous decision making to participate in screening, but at the same time the options available to them were restricted through the expectations around cervical screening that were communicated to them through medical discourse and discourses of femininity. Through engaging with dominant discourses, women construct their participation in cervical screening as consistent with their subjective experience as an empowered health consumer. At the same time, as dominant discourses legitimise and make more available certain courses of action, the choices available to women around cervical screening are limited.

Participants described some of the moral values inherent in cervical screening, and notions of individual and social responsibility reflected a dominant neoliberal discourse. The link between sexual activity and cervical cancer added another moral dimension to constructions of cervical cancer, and through drawing on discourses of morality, cervical screening was transformed into a moral issue. This placed the onus on to women to take part in cervical screening as part of good citizenship, and is consistent with other research which has described health and illness as morally charged and value-laden (Crossley, 2001).

Finally, through participants' experiences of vulnerability in the context of cervical screening, medical discourses were drawn upon to place faith in medical professionals to keep women safe from cervical cancer. At the same time, discourses of sexuality and femininity were drawn upon which disempowered women in the medical encounter as they participated in cervical screening. Through drawing upon medical discourse and discourses of sexuality and femininity, women released control of their bodies to be surveilled and regulated by the medical system. Women subject their bodies to governance and surveillance through engaging in dominant discourses which reinforce medical power (Lupton, 2012).

This research project focused on young women, between the ages of 20 and 30. This was a deliberate decision, both for the advantage of building whanaungatanga or connections between researcher and participants to facilitate discussion of a subject which may be tapu or sensitive, as well as for tapping into memories of first experiences of screening which would be more recent and salient for this age group compared to older women. At the same time, it is important to acknowledge that discourses are temporally and culturally bound (Phillips & Hardy, 2002), and that research conducted on an older group of women may have elicited very different responses, as they drew upon different discourses. The boundaries of socially acceptable sexual behaviour have expanded over time (Farvid & Braun, 2014), and the link between sexual activity, HPV and cervical cancer is communicated to people more now than in the past following the introduction of HPV vaccination for girls (Chelimo, Wouldes, & Cameron, 2010; The New Zealand HPV Project, n.d). For young women this may mean that the moral lens placed over cervical screening through the involvement of sexual activity may be experienced differently, both through more permissive and flexible discourses of sexuality which are less likely to treat sexual behaviour as a moral transgression, and through increased awareness of the biological mechanism linking sexual activity and cervical cancer. Future research could explore the experiences of older groups of women, with less of a focus on first experience of cervical screening, to explore how temporally bound discourses can create different experiences of cervical screening for different generations of women.

The original aim for this piece of research was to explore young women's understandings and experiences of cervical screening and human papillomavirus (HPV). However,

throughout the course of conducting interviews and analysing the data, it became clear that HPV was of secondary importance to cervical screening, with participants having limited knowledge of HPV and not discussing it in much detail. HPV thus became an auxiliary item to explore, with the focus of the research being on cervical screening only. HPV is an important topic to investigate, particularly as the New Zealand Cervical Screening Programme will move to HPV testing as the primary tool used in cervical screening in the next few years (National Screening Unit, 2016), which will make HPV a more central aspect of the cervical screening experience. Exploring how HPV is constructed and understood by women is important for considering how the change to HPV testing is likely to be experienced by women. Given that the women in the study had limited understandings of HPV, some seeing it as irrelevant to them, and others reflecting on how its link to sexual activity could create stigma, the shift to HPV testing may lead to changes in how women engage with the cervical screening programme. It is important that constructions of HPV are further explored in future research, as HPV becomes more salient to women as it begins to form a more central part of their cervical screening experience with the change to the cervical screening programme.

This research has explored cervical screening in a unique way, differing from the bulk of research into cervical screening, which has largely focused on barriers to cervical screening participation. This research adopted a critical stance, and rather than aiming to locate within an individual reasons for not participating in cervical screening in order to change the individual, it considered how discourses shape people's realities, functioning to privilege certain worldviews while marginalising others. This research acknowledged that reality is socially constructed, and health is not a morally neutral objective entity. Cervical screening was located within its broader social context, and the research explored how dominant discourses create a coercive environment, limiting the choices available to women, transforming cervical screening into a moral issue, and creating a sense of vulnerability that drives women to surrender control over their bodies.

Rather than assuming the goal of research into cervical screening is to increase participation, this research did not promote any particular health behaviours, accepting instead that prescriptive health behaviours are morally bound and cannot be considered neutral. Individuals do not exist in isolation, as rational beings who make choices fully



autonomously and free from the influence of social context. Instead, our very experience of reality is contextualised within our social world, our experiences and our social roles, which are created by our culture and social interactions. When exploring women's experiences of cervical screening, the way that social context restricts women's choices, moralises their behaviour and prescribes right and wrong ways of being women needs to be considered. This research examined this social context, and the impact this has on how cervical screening is constructed for women.

By making visible the dominant discourses which subject women to surveillance and control their bodies, we can challenge the status quo. This is not to say that this research intends to decrease participation in cervical screening, but instead it has highlighted that it is inadequate to view participation as something individuals ought to freely choose to participate in. The notions of ought and free choice are incompatible since, as Howson (1999) states, the inclusion of the idea of ought makes something into an issue of moral obligation.

Some practical applications for this research could be its use in health policy and medical encounters. By highlighting the coercive nature of cervical screening messaging, it is possible to change the approach used. Rather than all health policy and resources being driven by the goal of increasing screening participation, it could emphasise informed decision making, and work to empower women to make the right decision for them when it comes to cervical screening. This would be more consistent with the code of patients' rights which underpin the New Zealand health system (HDC Code of Health and Disability Services Consumers' Rights Regulation 1996). With less focus on individual behaviour change, and more attention to social context, health policy can work to facilitate women to decide what is best for their own health, and retain control over their own bodies. By making visible the moral dimensions that surround cervical screening, and particularly in relation to sexual behaviour, the broader social structures which control women's bodies and ways of being can be challenged.

The research explored the power imbalance present in the interaction between medical professional and patient, which has been described in previous research (Waitzkin, 1989), along with how constructions of femininity disempower women in the medical encounter (Gunn & Douglas Varus, 2010). It considered how these two processes interact in the

context of cervical screening to create a scenario where women feel compelled to surrender their bodily autonomy. The research found that recognition of the power imbalance and dealing with it sensitively influenced the cervical screening experience for women, something which could be implemented by medical professionals in their interactions, acknowledging the discourses which disempower women in this setting and working to challenge them.

We can all benefit from seeing how linking someone's worth as a person to how they express their sexuality, or through whether they take what are deemed to be suitable precautions to avoid falling ill, can be harmful, and we can work as a collective to change this. The involvement of sexual behaviour in women's experiences of cervical screening is particularly important when considering specific groups of women, such as those from more conservative cultures, and with strong religious values. Previous research has found that groups such as Māori and Pacific women, women with disabilities and those with a history of violence or abuse are more likely to find the sexual or taboo aspects of cervical screening a barrier to participation (Foliaki & Matheson, 2015; Lovell, Kearns, & Friesen, 2007; Peters, 2012), and this research explored how the sexual aspect of cervical screening was experienced by women, in its involvement in feelings of vulnerability, and through adding a moral dimension to the experience. What we can take from these findings is that rather than looking to make women more comfortable to facilitate them in taking part in cervical screening, we need to challenge the notion that a woman's worth is dependent on her sexuality and sexual behaviour. By addressing this, women are not tasked with overcoming their discomfort to take part in screening, but are empowered to make a decision free from a sense of fear or guilt.

This research demonstrated the social forces which work to control women's bodies. Dominant discourses are created through power structures, and drawn upon to maintain them. Through this, women's bodies become a site of surveillance and control. Coercion, morality and fear are utilised in this social process to direct women into obediently behaving in certain ways. Cervical screening is thus transformed into a tool by which women are subjected to governance and control. By applying the findings of this research and considering the social context of cervical screening, the way that women's bodies are surveilled, policed, and subjected to regulation can be challenged.

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## Appendices

### Appendix A: Participant Information Sheet



MASSEY UNIVERSITY  
COLLEGE OF HUMANITIES  
AND SOCIAL SCIENCES  
TE KURA PŪKENGĀ TANGATA

## New Zealand women's understandings of cervical screening and HPV

### Information Sheet

#### About the Researcher

My name is Holly Coulter and I am doing this research project as part of my Masters of Science in Psychology at Massey University, under the supervision of Professor Kerry Chamberlain.

#### The Research Project

In this research, I want to find out about what women's understandings and experiences are of cervical screening (smear tests) and human papillomavirus (HPV). This will mean having a conversation about these topics, and I will use the answers from the people I speak with to understand how women feel about smear tests and HPV.

You are invited to take part in this research, and it is your choice whether to take part or not. If you don't want to take part, you don't have to give a reason. If you do want to take part now, but change your mind later, you can pull out of the study at any time up to two weeks after the interview.

#### What you will be asked to do

I will interview you about cervical screening and HPV and what your thoughts are on these topics. The interview will take 60 – 90 minutes, and at the end I will review what we have talked about with you. The interview will take place in a place that is convenient for you, in a private room either at Massey University in Albany or a local library in Auckland

#### What happens to the data

I will record our interview so that I can write it up later. The recording will be stored securely, the only people who will have access to it are myself and my supervisor. When I write up the results of this study, I will make sure that your privacy is protected, and nothing that has been said can be used to identify you in any way.

### Privacy and your rights

Taking part in this study is completely optional, and you can decide not to take part at any time.

During the interview, you can at any time:

- Ask any questions about the study you think of;
- Ask me to stop the tape recorder;
- Decide not to answer anything I ask;
- Tell me that you want to withdraw something you said;
- Stop the interview;
- Withdraw from taking part and have me delete the recording.

Your name and anything that could be used to identify you will not be used anywhere in the study, to make sure your privacy is protected.

After your interview, if you decide you no longer want to take part you can withdraw at any time, up until 2 weeks after the interview. This is because once I write up the results of the interviews, it will not be possible to tell who said what and remove a particular person's responses.

After the study is finished, I can send you a summary report if you wish. There will be a section on the consent form that you sign where you can give your contact details if you would like a summary report.

**If you would like to take part in this research, please contact me by email or telephone (my details are below). Thank you.**

#### Contacts

Holly Coulter  
Researcher  
[hcou055@aucklanduni.ac.nz](mailto:hcou055@aucklanduni.ac.nz)  
022 102 9910

Professor Kerry Chamberlain  
Supervisor  
[k.chamberlain@massey.ac.nz](mailto:k.chamberlain@massey.ac.nz)

**This project has been reviewed and approved by the Massey University Human Ethics Committee: Northern, Application 16/07. If you have any concerns about the conduct of this research, please contact Dr Andrew Chrystall, Chair, Massey University Human Ethics Committee: Northern, telephone 09 414 0800 x 43317, email [humanethicsnorth@massey.ac.nz](mailto:humanethicsnorth@massey.ac.nz).**

## **Appendix B: Recruitment email sent to Women's Health Action mailing list**

Kia ora,

My name is Holly Coulter, and I am seeking participants for a research project as part of Masters of Science in Health Psychology.

In this research, I want to find out what women's understandings and experiences are of cervical screening (smear tests) and human papillomavirus (HPV). This will mean having a conversation about these topics, and I will use the responses from those I speak with to understand how women feel about smear tests and HPV.

I am looking for women who are aged 20-30 years old. It does not matter whether you regularly attend cervical screening or not.

I have attached to this email a participant information sheet, which explains a bit more about the research. The interview would take about 60-90 minutes, and would take place either in a room at Massey University Albany or somewhere else in Auckland which is convenient for you. I'll provide some food and drink during the interview, and you will receive a petrol voucher for taking part.

Please feel free to circulate this email to anyone who you think might be interested in taking part in this research.

If you would like to take part or have any questions, you can ring me on 022 102 9910, or email [hcou055@aucklanduni.ac.nz](mailto:hcou055@aucklanduni.ac.nz).

Thank you,

Holly Coulter

**This project has been reviewed and approved by the Massey University Human Ethics Committee: Northern, Application 16/07. If you have any concerns about the conduct of this research, please contact Dr Andrew Chrystall, Chair, Massey University Human Ethics Committee: Northern, telephone 09 414 0800 x 43317, email [humanethicsnorth@massey.ac.nz](mailto:humanethicsnorth@massey.ac.nz).**


## Appendix C: Facebook post to recruit participants - Massey University Extramural Community group

Massey University Extramural Community

paraphrase all the stuff I wrote at the beginning of the term again

2 13 Comments

Like Comment



**Holly Coulter**  
May 27

Hey fellow extramural students,  
If any of you are female, aged 20-30 and based in Auckland, it would be AHMAZING if you could help me out with my Masters research project 😊  
I am seeking participants for a research project as part of my Masters of Science in Health Psychology.

In this research, I want to interview women to find out what your understandings and experiences are of cervical screening (smear tests) and human papillomavirus (HPV).

I am looking for women who are aged 20-30 years old. It does not matter whether you regularly attend cervical screening or not.

The interview would take about 60-90 minutes, and take place somewhere convenient for you. I'll provide some food and drink, and you will receive a petrol voucher for taking part.

Please feel free to share this to/tag anyone who you think might be interested in taking part in this research.

If you are interested in this, please comment below or email [holly.coulter.1@uni.massey.ac.nz](mailto:holly.coulter.1@uni.massey.ac.nz) and I can send you more information.


Thank you,  
**Holly Coulter**

2 14 Comments

Like Comment

## Appendix D: Facebook post to recruit participants - Auckland Women's Centre page

Visitor Posts

 **Holly Coulter** ▸ **Auckland Women's Centre**  
May 27 · 🌐

Kia ora,  
I am seeking participants for a research project as part of my Masters of Science in Health Psychology.


In this research, I want to interview women to find out what your understandings and experiences are of cervical screening (smear tests) and human papillomavirus (HPV).

I am looking for women who are aged 20-30 years old. It does not matter whether you regularly attend cervical screening or not. The interview would take about 60-90 minutes, and take place somewhere convenient for you. I'll provide some food and drink, and you will receive a petrol voucher for taking part.

Please feel free to share this to/tag anyone who you think might be interested in taking part in this research.

If you are interested in this, please comment below or email [holly.coulter.1@uni.massey.ac.nz](mailto:holly.coulter.1@uni.massey.ac.nz) and I can send you more information.

Thank you,  
Holly Coulter

👍 1 

👍 Like    💬 Comment    ➦ Share

**Appendix E: Interview schedule**

The interview process will start with me greeting participants at interview venue. This will either be at Massey University Albany, or in a local library depending on what suits the participant best.

Participants will then be offered something to eat and drink, and then presented with a copy of the participant information sheet – which they will keep. I will verbally go through the information sheet in plain language, checking that participants understand each part, and giving them an opportunity to ask any questions they may have.

I will then invite participants to complete a consent form if they want to take part in the research, as well as indicate if they would like to receive a summary report after the research has been completed.

After this, the interview itself will begin. The interview will be participant-driven, and take a conversational format. I will ask participants to speak freely about certain topics, and probe for more depth as needed. Questions will be framed as an invitation to speak, such as 'tell me about what cervical screening or smear tests mean to you'.

Topics that will be covered include:

- understandings around cervical screening and HPV
- experiences with cervical screening
- feelings of shame and stigma
- compliance and obligation
- sexuality
- physical health
- family
- spiritual/religious beliefs

Following the interview, I will conduct a reflective session with the participants. I will review what we have talked about and my understanding of it, and give an opportunity for the participant to correct or clarify anything. If anything has been distressing for participants, I will provide them with the phone number of a helpline they can call. If participants have

expressed an interest in getting further information on screening, I will give them information resources from the National Cervical Screening Programme.

After this, I will thank the participants for their time and answer any final questions. I will check they have my contact details in case they have any further questions or want to withdraw from the study after the interview. Participants will be also be given a petrol voucher.



## Appendix F: Participant consent form



**MASSEY UNIVERSITY**  
 COLLEGE OF HUMANITIES  
 AND SOCIAL SCIENCES  
 TE KURA PŪKENGĀ TANGATA

### New Zealand women's understandings of cervical screening and HPV

#### Consent Form

I have read the Information Sheet and have had the details of the study explained to me. My questions have been answered to my satisfaction, and I understand that I may ask further questions at any time.

I agree to participate in this study under the conditions set out in the Information Sheet.

**Signature:**

**Date:**

.....

**Full Name - printed**

.....

If you would like to be sent a summary report of this research, please include a mailing OR email address below:

Address: .....  
 .....  
 .....

Email address: .....

### **Appendix G: Interview questions (original version)**

If you remember, can you tell me about how you first found out about cervical screening or smear tests?

*If required: what were your thoughts and feelings about smear tests when you found out about them?*

Can you tell me about your experiences of being asked or told to come in for a smear?

*If required: Do you remember a doctor, nurse or receptionist talking to you about smears? What was that like?*

[If required] Have you ever had a smear? Tell me about that/what deciding not to have a smear was like?

Tell me about your first experience of having a smear test.

*If required: What did you think of/ how did you feel towards the person who took your smear?*

*Did you understand why you were having a smear?*

*How did you feel before/during/afterwards?*

Have you ever talked about smear tests with your friends, partner, family or whanau? Tell me about those conversations.

*If required: For example, if you ever talked with your friends about the experience of having a smear, if you ever talked to family or friends about whether or not to have a smear, if you ever talked to someone about what smear testing is for.*

*What were those conversations like for you?*

Tell me about how you feel about smear testing.

*If required: What do you think about smear testing?*

*How important do you think it is?*

*How positive or negative do you feel about smear tests?*

*How would you feel before a smear test [do you think]? What about during? What about after?*

Tell me about the last time you went for a smear [if not already discussed]

*If required: How did you feel before/during/after?*

*Was this similar to how you felt towards your first/other smears?*

*How did it make you feel about the next time you are asked to come in for a smear?*

What is your understanding of what smear tests are for?

*If required: What do you think the purpose of smear tests is?*

*What do you think an abnormal/unusual result means?*

*What do you know about HPV (sometimes called human papillomavirus)? [if they have mentioned HPV]*

What is your understanding about cervical cancer?

*If required: What do you think causes cervical cancer?*

*How do you feel about people who have cervical cancer?*

What do you think about getting an abnormal/unusual result from a smear – that is, being asked to come in for further tests?

*If required: Has this ever happened to you? How did you feel when/how would you feel if it happened to you?*

*What about if it happened to someone you know?*

How do you feel about [other] people who do not go to have smear tests?

*If required: If someone told you they didn't go for smear tests, what would you think?*

*How do you think other people feel about people not going for smear tests?*

*How do you think doctors feel about people not going for smear tests?*

Now I just need to ask some background questions. You will be completely anonymous in the research, I just need to give some general information on participants.

How old are you?

What ethnicities do you identify as?

And what sexual orientation do you identify as?

## Appendix H: Cervical screening resources offered to participants

National Cervical Screening Programme. (2007). *Cervical Screening: What Pacific women need to know* [Pamphlet]. Retrieved from

<https://www.healthed.govt.nz/system/files/resource-files/HE1831-CS%20Brochure%20PacificWEB.pdf>

National Cervical Screening Programme. (2009). *Prevention of Cervical Cancer: A Guide for Women in New Zealand* [Brochure]. Retrieved from

[https://www.healthed.govt.nz/system/files/resource-files/HE1328\\_Prevention\\_of\\_cervical\\_cancer.pdf](https://www.healthed.govt.nz/system/files/resource-files/HE1328_Prevention_of_cervical_cancer.pdf)

National Cervical Screening Programme. (2013). *Cervical Screening: What Wāhine Need to Know/Atawhaitia te Wharetangata* [Pamphlet]. Retrieved from

[https://www.healthed.govt.nz/system/files/resource-files/HE1837\\_Cervical\\_Screening\\_Maori.pdf](https://www.healthed.govt.nz/system/files/resource-files/HE1837_Cervical_Screening_Maori.pdf)

National Cervical Screening Programme. (2014). *Cervical Smear Tests: What women need to know* [Pamphlet]. Retrieved from

<https://www.healthed.govt.nz/system/files/resource-files/HE1256%20Cervical%20Smear%20Tests%20What%20Women%20Need%20to%20Know%20%E2%80%93%20English%20version.pdf>

## Appendix I: Interview questions (revised version)

If you remember, can you tell me about how you first found out about cervical screening or smear tests?

*If required: what were your thoughts and feelings about smear tests when you found out about them?*

Can you tell me about your experiences of being asked or told to come in for a smear?

*If required: Do you remember a doctor, nurse or receptionist talking to you about smears?*

*What was that like? What was the doctor like?*

[If required] Have you ever had a smear? Tell me about that/what deciding not to have a smear was like?

Tell me about your first experience of having a smear test.

*If required: What did you think of/ how did you feel towards the person who took your smear?*

*Did you understand why you were having a smear?*

*How did you feel before/during/afterwards?*

*How might it have gone differently? What would have made it a less positive/negative experience? How might that affect how you felt afterwards?*

Have you ever talked about smear tests with your friends, partner, family or whanau? Tell me about those conversations.

*If required: For example, if you ever talked with your friends about the experience of having a smear, if you ever talked to family or friends about whether or not to have a smear, if you ever talked to someone about what smear testing is for.*

*What were those conversations like for you?*

Tell me about how you feel about smear testing.

*If required: What do you think about smear testing?*

*How important do you think it is?*

*How positive or negative do you feel about smear tests?*

*How would you feel before a smear test [do you think]? What about during? What about after?*

Tell me about the last time you went for a smear [if not already discussed]

*If required: How did you feel before/during/after?*

*Was this similar to how you felt towards your first/other smears?*

*How did it make you feel about the next time you are asked to come in for a smear?*

What is your understanding of what smear tests are for?

*If required: What do you think the purpose of smear tests is?*

*What do you think an abnormal/unusual result means?*

What do you know about HPV (sometimes called human papillomavirus)? [if they have mentioned HPV]

*Tell me about your understanding or experience of HPV? Where did you find out about it?*

*Do you feel at risk of HPV?*

*Where do you think it come from?*

*What would you think if someone told you they had HPV?*

*What about if you were told you had HPV?*

What do you understand about the HPV immunisation and what it does?

*Were you offered the immunisation?*

*Tell me about what that was like?*

*Did you feel like you understood what it was?*

*Did you feel like you were able to decide for yourself whether to have it?*

*What did you think about people who didn't have the immunisation? What about girls who did?*

What is your understanding about cervical cancer?

*If required: What do you think causes cervical cancer?*

*How do you feel about people who have cervical cancer?*

What do you think about getting an abnormal/unusual result from a smear – that is, being asked to come in for further tests?

*What do you think causes abnormal smears?*

*If required: Has this ever happened to you? How did you feel when/how would you feel if it*

*happened to you? Do you/did you think beforehand that it was something that could happen to you?*

*Has it happened to someone you know? What did you think/how would you feel?*

How do you feel about [other] people who do not go to have smear tests?

*If required: If someone told you they didn't go for smear tests, what would you think?*

*How do you think other people feel about people not going for smear tests?*

*How do you think doctors feel about people not going for smear tests?*

*If you decided not to go for smears, how do you think some of the people in your life would react? OR When you decided not to go for smears, what were some of the reactions from your doctors/anyone in your life that you told?*

*What do you think are some of the reasons why someone might decide not to go for a smear?*

How do you think your upbringing has influenced how you feel about smears?

*Like your experience with your family? How might someone from a different family feel differently?*

*What about cultural factors? How do you think someone from a different culture might feel different?*

*And what about any religious beliefs? And what about someone from another religion?*

For you, where do you think smear testing fits in with other health practices you do – do you think of it as part of sexual health or as taking care of your health generally?

*How might that link in to how you feel about smear testing?*

Now I just need to ask some background questions. You will be completely anonymous in the research, I just need to give some general information on participants.

How old are you?

What ethnicities do you identify as?

And what sexual orientation do you identify as?