University of Alberta

Spider Weaving: STI/HIV Prevention Using Popular Theatre and Action Research in an Indigenous Community

by

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ABSTRACT

A pocket of HIV infection has grown to epidemic proportions in a mostly Aboriginal[1] community in Northern Alberta. At the start of the research my assumptions were that Aboriginal[2] sexuality is affected by political, historical, cultural, psychological, and social factors that underpin the social determinants of health. STI/HIV is a symptom of the marginalized status of Aboriginal peoples who experienced historical trauma due to colonization. As an insider researcher, using an exploratory design I addressed the following questions: 1) is popular theatre a culturally appropriate medium for introducing information to increase knowledge of STI/HIV in an Aboriginal audience? 2) Is popular theatre an effective way to encourage audience members to express their attitudes, knowledge, and behaviours related to sexual health? 3) How are popular theatre and action research methodologically and conceptually appropriate for preventing STI/HIV? 4) How do the influence of elders and a popular theatre practitioner affect the intervention? 5) Can the use of action research and popular theatre influence the attitudes, knowledge, and behaviours to promote healthy sexual choices? 6) Is narrative analysis a good way for Aboriginal people to tell their stories or have their stories told? Completing this exploratory research was financially possible through the Aboriginal Health Strategy. The funds enabled me to recruit a popular theatre practitioner, a group of young Indigenous community members and supportive elders to answer my research questions. The data was obtained through one-to-one interviews, journals, talking circles, and field notes of the community-based theatre and action research process. Due to a lack of time in the field, narrative analysis was not used. Instead I introduced Grandmother Spider and developed a dream catcher that I refer to as the Indigenous Iterative Webbed Circle to analyze the real and fictional stories that led to the community performance of “My People’s Blood.” The methods are appropriate and effective if the principles of Community Based Participatory Research and action research are followed by all group members involved in this popular theatre project.

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[1] This community where this research was conducted includes First Nations and Métis not Inuit.
[2] Aboriginal as defined the Canadian Constitution includes First Nations, Inuit and Métis peoples.

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To my family, I would like to thank my loving daughter Chloe for contributing to the greater good of our people and to my son Zach, daughter Nicola, and grandson Dakota, kisahkihtin[3].

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[3] A Cree term for I love you.

TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

CHAPTER ONE: INTRODUCTION

As a talk-show host of a low budget television program in the early 1990s, I became intensely interested in HIV prevention and I used the current affairs show to introduce the viewers to people who were making headlines in the Aboriginal community. In addition to the constitution talks, blockades, and social problems that plagued the Indigenous community in Canada, maintaining and achieving health was becoming more political as HIV/AIDS was “relentless” (Lambert, 1993, S46). I invited Ken Ward and Denise Lambert to the television studio to address HIV prevention in the Aboriginal community. Ken Ward was the first Aboriginal male in Canada to publicly disclose that he had the virus that causes AIDS. He had become infected during the 1980s. Denise Lambert was an advocate for HIV/AIDS prevention. Together they pioneered the discourse on HIV/AIDS in the Aboriginal community in Alberta. My interest in STI/HIV prevention began at this point. Over time the virus spread; the statistics steadily increased. Over fifteen years later, HIV/AIDS has spread globally, nationally, regionally, and of particular concern to me, within the Aboriginal community.

I pursued an education in public health sciences to address STI/HIV among Indigenous peoples. Since the field of public health sciences includes health promotion, injury and disease prevention, health surveillance, and population health, and this field has been described by Charles Edward A. Winslow, the American Public Health leader, as “the science and art of preventing disease, prolonging life and promoting health and efficiency through organized community effort,” I chose this interdisciplinary field to focus on prevention at the community level (Winslow, 1920). Specifically, I entered the population health program. The focus of population health is to improve the health outcomes of groups of individuals by examining the distribution of health across the group (Kindig & Stoddart, 2003). “The field of population health includes health outcomes, patterns of health determinants, and policies and interventions that link these two” (Kindig & Stoddart, 2003). My focus within the population health program was to examine the social determinants of health[4] and the broader determinants of health from an Aboriginal perspective[5] and develop a culturally appropriate intervention. In this dissertation, I posit that health research with Aboriginal people and the analysis of Aboriginal health research be examined through our cultural lens. I took a community-based approach to health.

In 2005, I conducted my STI/HIV prevention research using popular theatre and community-based participatory research (CBPR)[6] in an Aboriginal community in Northern Alberta. Some people within this Aboriginal community had died of AIDS related causes and some community members spoke about how one person or another died of "cancer." I wondered if the person talking preferred to identify cancer as the culprit rather than state that she died of AIDS to avoid dealing with a socially unacceptable disease. Then there was the gossip I heard of how so-and-so was a "carrier" of the virus that causes AIDS. For those who were living in this small town with HIV, finding acceptance would have been difficult. People feared being associated with anything related to AIDS. The social environment prevented local health care workers and researchers from carrying out consistent and effective STI/HIV prevention. In this climate of shame and denial, I kept thinking about more people becoming infected and wondered how the community could begin to effectively address prevention. As a researcher I wondered what health interventions would help the community overcome the barriers to building a healthier community. I wondered if popular theatre and action research could prove to be effective tools in STI/HIV prevention.

I thought of using the action research spiral because it is iterative and reflexive. I thought popular theatre would capitalize on the oral tradition of Aboriginal peoples. I seized this opportunity to use these

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[4] The Public Health Agency of Canada (2007) identifies twelve determinants of health that include income and social status, social support networks, education and literacy, employment/working conditions, social environments, physical environments, personal health practices and coping skills, healthy child development, biology and genetic endowment, health services, gender, and culture.

[5] The National Aboriginal Health Organization (2006) identifies broader determinants of health in an Aboriginal context as colonization, globalization, migration, cultural continuity, territory, access, poverty, and self-determination.

[6] Minkler & Wallerstein (2003) state that public health, social work, and related fields use the term community based participatory research to describe an orientation to research that includes action research, participatory research, participatory action research, mutual inquiry, and feminist participatory research. In this thesis I use CBPR, action research and the action research spiral interchangeably.

methods to address a disease that could decimate the Aboriginal population to examine and re-examine the research questions introduced in the abstract and discussed in Chapter Three. The research field with respect to the Aboriginal population and AIDS was barren and I carried the burden of promoting sexual health in a meaningful way. The work was challenging but rewarding.

I recruited a core group of young Aboriginal co-researchers who became actors and a supportive group of elders, along with a popular theatre practitioner. Our goal was to create a play with an STI/HIV prevention message. In order to accomplish this goal, the group explored the community factors leading to STI/HIV and performed and discussed the themes of the play with the community. In my analysis of the results I identified social, cultural, psychological, historical, and political factors which underpin the determinants of health. These factors underlie the spread of infection.

After completing this community intervention, I found myself struggling to find a way to analyze the layers of results. There were no established methods to analyze both real stories and fictionalized stories, from an Indigenous perspective. So I looked to the humanities and the work of Indigenous writers and rediscovered Spider Woman,[7] an entity that would enable me to create a model to analyze my results while respecting the stories that were shared. I used a dream catcher[8] and developed the Indigenous Iterative Webbed Circle to link Aboriginal health concepts with mainstream health care concepts while working from a popular theatre and action research perspective. Given that this research was exploratory, I developed a model and analyzed the results based on Indigenous concepts and values that include kindness, honesty, caring and strength. The journey of analyzing and reporting the results has been slow but many barriers were overcome and it has been a journey of discovery.

The Statistics

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[7] Spider Woman is synonymous to Grandmother Spider and Earth Woman (Gunn Allen, 1986).

[8] Grandmother Spider has spun a silken web within a red willow. It is a dream catcher. It is a piece of willow with thread like sinew resembling a spider web with either seven or eight or thirteen points. Dream catchers started to resurface in the nineteen sixties and seventies. Spider Woman, or one aspect of her, has shared a gift with Indigenous people and although it is not clear which tribe had the dream catcher first, it existed because of the belief in her and the power of the oral tradition.

The AIDS Calgary Awareness Association released the HIV/AIDS statistical summary in January 2008. In 2007, the estimated number of males, females and children living with HIV was 33.2 million world-wide (UNAIDS: AIDS Epidemic Update – Dec. 2007). In 2007, 2.5 million more people were infected with the virus (UNAIDS: AIDS Epidemic Update – Dec. 2007). That same year, 2.1 million people died of AIDS (UNAIDS: AIDS Epidemic Update – Dec. 2007). “Since the epidemic began AIDS has killed more than 25 million people” (UNAIDS: AIDS Epidemic Update – Dec. 2007).

In Canada, from 1985 to 1994, there were 32 838 positive HIV test reports during those years (Public Health Agency of Canada, 2007, p.1). By June 2007, there were 63 604 cases reported to the Public Health Agency of Canada (p. 1). From 1985 to 2007, the cumulative number of positive HIV tests reported by age showed that 99.2% of the cases were fifteen years of age and older (p. 2). The cumulative number of people living with HIV from 1985 to 2001 in the following provinces show that Ontario (21 913 cases), Quebec (11 183 cases), British Columbia (10 541 cases), and Alberta (3 656 cases) have the highest numbers of people living with HIV (Public Health Agency of Canada, 2007, p. 6). In Alberta there was a fluctuating trend in the number of new HIV cases. The range was from 160 new cases in 2003 to 221 new cases in 2006 (p. 6). The Public Health Agency of Canada[9] cautions against the interpretation of ethnicity data because not all provinces reported data using the ethnicity variable. Between 1979 and 2001 the percentage of HIV diagnoses who were Aboriginal was 2.9% (450/18986) and for whites 83.4% (12 760/18 986) (p. 10). The percentage then increased dramatically for Aboriginals. In 2002, 12.6 % (40/406) of the newly reported cases of HIV were Aboriginal, whereas 60.7 % (193/406) were white (p. 10). By 2007, Aboriginal peoples accounted for 15.4% (6/109) of the newly diagnosed cases, whereas whites accounted for 53.8% (21/109) (p. 10).

The Public Health Agency of Canada reports that the “infection rate [across the country] among Aboriginal persons is about 3.6 times higher than among anon-Aboriginal persons in 2008” (Public

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[9] According to the Public Health Agency of Canada ethnicity is not available for all provinces and territories. Quebec and Ontario do not collect ethnicity data on positive HIV test results. Therefore the Public Health Agency of Canada does not deem the results to be reflective of all Canada.

Health Agency of Canada, 2008). “The distribution of newly infected Aboriginal persons among exposure categories in 2008 was 66% IDU, 23% heterosexual, 9% MSM and 2% MSM-IDU” (Public Health Agency of Canada, 2008).

Data from 1998 to 2006 showed that, “Aboriginal ethnicity dominated in newly diagnosed HIV and AIDS cases in Northern Alberta” (Alberta Health and Wellness, 2008, p. 9). “Newly diagnosed HIV rates for First Nations males were 5.7 that of non-First Nations males, while rates for First Nations females were 14.8 times higher than non-First Nations females” (Alberta Health and Wellness, 2008, p. 9).

The Research Study

This research project was directed at Indigenous[10] people living in a Northern Alberta hamlet. My research goal was to address the hetero-sexual transmission of HIV among sexually active Indigenous people as it was the primary mode of transmission in this community. I considered action research and popular theatre, both non-linear methods, as vehicles to help prevent STI/HIV for a number of reasons. The action research spiral and inclusive nature of popular theatre are described (pp. 48-62). I considered using action research and popular theatre for two reasons. First, literacy levels are low; only 30% (N=203) of the Nation’s members have completed a high school education (Cardinal, 2000). Second, sex is a particularly sensitive topic in Indigenous communities because of the abuse experienced in residential schools (Berry, 1999). In this project, action research and popular theatre focus on the spoken word, journal writing, and the body to express stories developed from lived experience. Since completing this research, I would espouse that when these methods are used together in this particular cultural context, they are holistic, in that participants engage their mind, body and spirit. By sharing stories of related experiences, people begin to break the silence. These methods are empowering. I felt that working with a small core group of Indigenous youth would foster the trust necessary for the sharing process of story development. This project was intended to promote STI/HIV awareness and prevention among an

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[10] The term Indigenous is interchanged with Aboriginal, First Nations, Indian and Cree.

Indigenous population affected by low literacy levels with a sensitivity towards sexuality and to empower the community to discuss a taboo subject.

The Assumptions for the Study Design

STI/HIV Prevention Using Popular Theatre and Community-Based Participatory Research in an Aboriginal Community was the working title of my research. My underlying assumptions of this research were that:

1) Aboriginal sexuality is affected by political, historical, cultural, psychological, and social factors.
2) STI/HIV among Aboriginal people is a symptom of the underlying political, historical, cultural, psychological, and social factors.
3) High rates of STI/HIV infection imply a serious problem that needs to be addressed politically, historically, culturally, psychologically, and socially.
4) Popular theatre and community-based participatory research are helpful methods towards addressing STI/HIV prevention in that when their principles are fully embraced these approaches address political, historical, cultural, psychological, and social factors.
5) Among Aboriginal populations STI/HIV prevention requires a bi-cultural[11] approach to program development and more cultural awareness by researchers and members of the Indigenous community. STI/HIV research involving Indigenous populations ought to be holistic and inclusive of Indigenous ways of knowing in addition to the Western research approach.

These underlying assumptions underpinned the research. To test the assumptions, I required an exploratory study design that employed inductive logic (Shi, 1997, p. 126). The conclusions are discussed in the final chapter. Conducting STI/HIV prevention in this particular Indigenous community was a step towards an understanding of whether or not qualitative, community-based participatory research and popular theatre methods can help address STI/HIV prevention in an Indigenous community while

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[11] Bicultural implies presenting two streams of knowledge, from mainstream and Aboriginal perspectives.

stepping away from the use of statistics, experimental designs[12], and survey research. The type of research required a flexible, open, design that would allow for change during the course of the study as a result of "new or unforeseen events" (Shi, L., 1997, p.134). During this research project there were many unforeseen events, therefore having an exploratory study design allowed the co-researchers the flexibility to adapt to the circumstances. By using these research methods in a culturally driven way, I was able to engage a core group of young people and elders to address this highly sensitive topic. Whereas the topic was next to taboo in the early stages of the study, the community project led to an empowering public event where the young people presented a play about HIV/AIDS issues successfully to our community; the audience was completely engaged and discussed STI/HIV prevention afterwards openly and publicly. From this research, I have drawn conclusions about the processes, devised a way of analyzing the results in order to present the personal and fictionalized stories for knowledge translation and provided knowledge exchange of substance.

Assessing the Community Project

In my search for a way to analyze the data, I developed a dream catcher model that I refer to as the Indigenous Iterative Webbed Circle. I created this model to help position myself in the context of the research and analysis in the field of public health. This model includes aspects of the Ontario Aboriginal Health Policy Model[13], a popular theatre[14] framework, and action research spiral. I focus on the public health aspects of the Ontario Aboriginal Health Policy Model. While the United Nations' World Health Organization (1946) defines health holistically as "a state of optimal physical, mental and social wellbeing, and not merely the absence of disease or infirmity," my focus is broader, as explained in Chapter Three (Sutherland & Fulton, 1992, p. 8). Creating the Indigenous Iterative Webbed Circle

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[12] Experimental designs are also referred to as clinical trials that provide reliable epidemiological evidence about exposure status (Hennekens & Buring, 1987, p. 26).

[13] The Ontario Aboriginal Health Policy Model considers medicine and public health. The medical aspects are treatment and curative. The public health aspects are prevention and health promotion.

[14] Popular theatre refers to a process whereby plays are developed and performed for the people by the people.

allowed me to address the findings of the research project through a cultural lens which in turn can help conventional public health models for future prevention efforts aimed at Indigenous communities.

As an Indigenous researcher, I have a "duty and responsibility," to serve, nurture, protect, guide, and empower my community (Russell, 2000, p. 97). As a mature Indigenous woman within this community, my social role is to bring balance and harmony through Indigenous ways of knowing that include focusing on the greater good, enacting social change and prayer. This research was a spiritual journey. So, the study design stemmed from my self-concept as an Indigenous researcher who continues to learn what it is "to be Indian[15]" within the context of an Aboriginal community whose members have been impeded by colonization to become "self-actualized human beings[16]." When I was in the community, I paused momentarily to reflect on the enormity and difficulty of the challenge because undoing the damage of colonization will take a collective effort across generations. Duty and responsibility called and as I began, I took small steps forward leaning against the strong wind of colonization and finding it difficult to breathe in the wind let alone speak.

The absence of an Aboriginal consciousness makes it difficult to restore honour for Aboriginal people so I made a conscious effort to breathe and find my voice. Fyre Jean Graveline, Métis feminist and author, states that there is an absence of Aboriginal consciousness and this offers a clue about the "suppression/oppression of the Aboriginal worldview" (1998, p.35). Graveline quotes E. Fox-Genovese, (1991), to reify, "A hegemonic culture relies as much upon negation as upon positive affirmation for its binding force. The more negation can be inscribed in silence, the more binding it will be," (p. 237). Graveline stresses the importance of using the Aboriginal voice to speak and be heard, as a solution to challenging the dominant order of Western society even if it means speaking about bitterness. When we

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[15] The term stems from one's identification with human growth and potential to break free of the confines of colonization.

[16] This term is adopted from Maslow's hierarchy of needs whereby Blackfoot scholars, Narcisse Blood and Ryan Heavyhead have revisited Maslow's model. Maslow lived among the Blackfoot people in the 1930s. They argue that Maslow's hierarchy of physiological needs, safety needs, social (love) needs, esteem needs, leading to self-actualization stems from their traditional tipi teachings. Dintelman (2002) explains that unless the first four are met the person will not become self-actualized. Heavyhead & Blood identify missing components within Maslow's hierarchy of needs. Land and language components are missing from the Maslow model (personal communication).

are heard “the ground shifts,” claims Graveline, and she quotes Edward Said, “There are now two sides, two nations, in combat,” (1993, p. 207). In order to engage in this discourse it is important to know one’s culture and resist domination. Graveline states that, “through acknowledging and revealing ancestral ways of life, our cultural expressions can enhance emotions of pride as well as defiance” (1998, p. 41). The Métis author quotes Said (1993, p. 207), “local narratives, Elder’s autobiographies, and memoirs ‘form a counterpoint to the Western powers’ monumental histories, official discourses, and panoptic quasi-scientific viewpoint’” (p. 215). In this dissertation, the words of the elders and young people will be shared and discussed to give voice to Aboriginal sexuality, even if it means talking about bitterness due to historical and intergenerational trauma. The dissertation also addresses the research questions on the appropriateness of these methods in addressing STI/HIV prevention.

When a researcher is delving into Aboriginal sexuality in a geographic area that shows higher rates of STI and HIV, there is a need for ethical and cultural sensitivity. There is much philosophizing about conducting ethical research in Indigenous communities. Indigenous scholar Willie Ermine postulates on the “cultural tensions” that exist in research because of the confluence of worldviews that is an entangled mess of political, social, and intellectual knots. These knots indicate a “deeper undercurrent of hidden values and unnoticed cultural differences between the two entities” (Ermine, 2005, p. 1). Amidst the mess of tangled knots I found my voice as a writer addressing the tensions between the dominant Western-based notion of disease prevention and an Indigenous view of disease prevention.

There is a lack of knowledge about the cultural beliefs of Aboriginal peoples within academic institutions. When those beliefs are presented, First and Fourth World scholars are required to prove or defend those ideas. I am in the same situation. My research is an effort to elucidate Indigenous cultural concepts within STI/HIV prevention and health in general. While Indigenous knowledge exists, and has forever, it was my challenge to connect this knowledge with the problem at hand. It is not just a challenge of “defending” these beliefs and knowledge, but of showing the connections between the experience of colonization and Indigenous sexuality and the implications on the sexual health of Indigenous people today. If it was sufficient just to say that this knowledge exists, there would be no need to engage in the academic exercise of research, but there is a long historical tradition of academic research that must also be recognized.

Willie Ermine and other First and Fourth World scholars have recognized the knowledge of the "West" as a "result of the critical work of many thinkers and writers" (Ermine, 2005). Ermine states that, "Numerous critical programs have contributed to the sociocultural analysis of existing power structures and social inequalities that seek to end the privileged position of Eurocentrism and colonial thought in modern society and create parity in modern thought" (2005, p. 2). Although it is important to acknowledge the "colossal unseen dimensions" in order "to redesign a social system," it is not the scope of this thesis to do that (McIntosh, 1998, p. 168). I offer the Indigenous Iterative Webbed Circle as a way to answer my research questions regardless of the "cultural narcissism of the West" that is perceived as searching for power and control of what is other to it (Young, 1990). Ermine views eurocentrism as having an established consciousness that seems to undermine any attempts "to build bridges for the effect of cross cultural understanding and ethical relations between Indigenous Peoples and the West" (2005, p. 3).

I attempt to bridge cross cultural understanding by positioning myself in the research that I have done, and am now writing about, by introducing myself.

Who am I? Where am I in the research?

I am an Indigenous insider researcher writing about my community's struggle to prevent sexually transmitted infections including HIV. As an Indigenous researcher, I write from a holistic perspective on the process and outcomes with kindness, honesty, caring, and strength. These values are the ethical foundation of my analysis. I am a mediator of what I see as two circles, the Western and the Indigenous.

As a writer, sharing even a brief address about the holistic approach to writing and analysis is chilling because many, not all, academics are usually encouraged to be linear, to the point, calculated, unemotional and results-driven. Although no offense is intended I must acknowledge that the academic environment can be a difficult place to share Indigenous knowledge and find acceptance. As Linda Tuhiwai Smith (1999) states, "the supposed characteristics of primitive peoples was that we could not use our minds or intellects” (p. 25). From that ideology it would seem that Indigenous people cannot contribute to academia or society. The chill is compounded with the difficulties of addressing “the most intimate aspect of our being – the sexual creating part of men and women” (Lambert, 1993, S46).

Engaging in a discourse on STI/HIV prevention was of vital importance to me because it was in my community that statistics demonstrated high rates of STI/HIV and it seemed that the community was not doing enough to address the issue. I wondered whether my community’s members felt disempowered in addressing the stigma of STI/HIV. How could they counteract the truth of the statistics that present a dismal picture in a dehumanized way? Demonstrating culturally driven social and health change demonstrates my community’s resiliency and survival amidst another infectious viral plague. This community, as many other Indigenous communities, battles for “sheer physical survival” (Smith, 1999, p. 4). Aboriginal peoples have a story to tell. It is a story about how we have been abused, in some cases sexually abused as children, and how we have survived. Our stories are about healing the mind, body, and spirit. Therefore, my role as a researcher was to enable a dialogue on STI/HIV prevention in a culturally appropriate way. This was possible by working with young people, elders and a popular theatre practitioner. My role as a researcher was to encourage and enable people to hear one another while they shared stories about the importance of preventing STI/HIV.

The process began at ceremonies with a thought, a word, and a prayer. The smell of medicines burning offered a memorable familiarity that connected me to my ancestors. I recall holding my shawl in place with one hand and offering my tobacco and cloth in the other. I knelt carefully, my long skirt tucked beneath the back of my knees. I humbly presented my tobacco and other offerings to the elder who prayed to the other side, the ancestral side. I asked for blessings so that my work would be completed in a good way. This is what I believe to be the culturally appropriate way of obtaining the blessings. From the Indigenous perspective, it was a fundamental grounding part of the ancient holistic approach to seeking blessings from the grandmothers and grandfathers. Without the offering of protocol for a prayer, the words to engage others in this research would not have fallen into place, as much as they did.

Working with young people and elders, the popular theatre practitioner and I listened to stories that were shared about HIV and the group created a play entitled, “My People’s Blood.” The play was produced for a community audience and was received positively. It was a miracle and blessing! The many positive factors that enabled this to happen included: having academic support and friends and family to provide encouragement, the availability of an experienced popular theatre practitioner, having a committed group of young people to work with, support of the community and elders, and financial support from Alberta Health and Wellness which is now Alberta Health Services.

On this journey of obtaining an education in the Western world, I realized how my pragmatic view of valuing equality over superiority coincided with my beliefs as an Indigenous researcher. This realization conflicts with the historical hegemony of doctors within the scope of medical science that has its roots in the oppression of “irregular practitioners” that include but is not limited to nurses, midwives, osteopaths, chiropractors and opticians to a lesser degree (David, 1986, p. 20). While I believe that it is important to bridge the Western and Indigenous ways of knowing in order for Indigenous people to contribute to humanity as a whole, there was a gap in what was being offered by professors in the university classes. The gap in Indigenous knowledge within the academic institutions prevented the ceremonial discourse that was important to me. What one learns in the “Indian School” is different from what is learned on campuses. The elders in the bush, mountains, or prairies are professors in the “Indian School.” Their knowledge is based on a land-based culture, lived experience and wisdom. I believe that my role is to encourage a discourse between the Western and Indigenous worlds. This does not necessarily mean that I speak for people but that I may provide the means to enable people to hear one another.

I am an intermediary between the Western and Indigenous paradigms. I speak to the process and results of this research: STI/HIV prevention using popular theatre and community-based participatory research in an Indigenous community.

As I was thinking and writing on this topic, I realized that an explanation of my writing style was missing. I was writing about events that happened in the field that were highly emotional for the core group members and for me. Having been trained in the Western academic environment where the author/researcher is supposed to be a distant, neutral, third party, I found myself emotionally entwined with the group's experience. From the position of insider researcher, I wrote about events that included group bonding, learning about the elders' role and traditional knowledge, patience in the creative process, dealing with group conflict, STI/HIV testing, near-debilitating attendance issues, and the pressures of performing. On one hand, I felt that my voice was weak because it seemed as if I was writing from an emotional place that was far removed from the distant third person voice of the objective academic. On the other hand, from an Indigenous perspective that embraces the mind, body, spirit, and emotions, not writing from a first-person perspective would make me feel removed from the process that I was involved in. I felt it would be a dishonour to the knowledge gleaned from this process. Writing from a distant third person perspective did not seem to honour the journey that I took with my fellow community members nor did it enhance an Indigenous research paradigm. Both honouring the journey and embracing an Indigenous research paradigm are important for creating new knowledge. I found my voice when I found Grandmother Spider and created the Indigenous Iterative Webbed Circle. Grandmother Spider helped me to connect the layers of stories, real and fictional, with the political, historical, social, psychological, and cultural factors.

The subsequent chapters are organized in the following fashion.

In Chapter Two, the literature review offers various approaches to addressing STI/HIV from a public health perspective in the Indigenous community. It reviews of the literature on STI/HIV prevention projects in other Aboriginal communities in Canada and popular theatre and action research in other contexts as it applies to social and health problems. To tie this work to the larger public health field, I connect related concepts of community-based participatory research to this 2005 action research and popular theatre project. To provide a social context of the work, it also provides a background on Aboriginal sexuality throughout colonization and the social stigmatization of Aboriginal men and women. I define culture from the determinants of health framework and posit that Aboriginal health research ought to be designed and analyzed through a cultural lens. I advocate for a culturally-driven land-based educational approach that connects First Nations and Metis people to the Natural Laws, ceremonies, song and stories. Furthermore, my role as an Indigenous woman is to learn the Rites of Passage Ceremony and transfer sexual health knowledge to young women. In this way the significance of a culturally-driven land-based educational approach is highly significant to culturally appropriate education.

In Chapter Three, I discuss whether or not, and in what ways, action research and popular theatre are conceptually, methodologically and culturally appropriate for addressing STI/HIV prevention in an Indigenous community. I introduce Grandmother Spider and the Indigenous Iterative Webbed Circle which provides my analytic framework. An explanation of the methods of data collection and a discussion of research questions follow.

Chapter Four retraces the research pathways and processes. This journey included obtaining approval and support for the project. I explain the process to garner support from the elders, involve the popular theatre practitioner and recruit core group members. Lastly, I provide a chronology of events during the community-based research period.

Chapter Five discusses how STI/HIV testing became a significant part of the process and the empowering effect that this had on the group. Through their experience of testing the group members became advocates.

In Chapter Six, I re-introduce Grandmother Spider and the Indigenous Iterative Webbed Circle to help connect and analyze the data from the talking circles, journals, field notes, hand drawn pictures, and a graffiti wall that led toward an intervention. The popular theatre practitioner worked with the core group of young people to create characters and developed dramatizations of three stories which deal with community views of HIV/AIDS: Kehew and Pisim; Savannah and Buddy; and Alix’s Story, as part of the play, “My People’s Blood.”

In Chapter Seven, I consider the plot, characters, themes and similarities and differences of the three stories contained in the play. The stories reveal many aspects of how HIV/AIDS is understood in this community. Barriers to health and health promotion are revealed via an analysis of the stories which emerged from the CBPR and popular theatre processes. Using the determinants of health, I identify gaps in the play.

Chapter Eight includes the concepts of knowledge translation and knowledge exchange that are defined according to mainstream definitions and redefined from an Indigenous perspective. Examples of knowledge translation and exchange are presented.

Chapter Nine presents the research findings and offers recommendations through my analysis while answering the question: what lessons were learned and what would I do next time?

CHAPTER TWO: CONTEXT AND HEALTH

As Indigenous people[17], our culture forms our identity. The Creation stories that are rooted in circular teachings and Natural Law help us to connect back to our ancestral ways. Natural Law enables us, the Indigenous people, to "redirect your life to the principles of living in harmony with the natural world" (Benton-Banai, 2000, p. 4). These teachings are passed down from the elders to Indigenous people for their benefit. My purpose is to alert the readers to the importance of the oral tradition and symbolic teachings that connect Indigenous people to their heritage so they may understand the significance of sexual health and reproduction (SHR) as it applies to Cree people. I examine four areas. The first focuses on the effects of colonization on Aboriginal sexuality as it leads to the current spread of STI/HIV and stigmatization of Indigenous sexuality. The second topic focuses on STI/HIV prevention aimed at urban and rural Indigenous communities in Canada. The third focuses on the use of popular theatre and action research/community-based participatory research to address social and health issues. From this position, I interweave a cultural and historical perspective of First Nations' sexuality with the need for STI/HIV prevention using a cultural foundation.

Indigenous people have experienced changes to their way of life due to colonization. The changes affected First Nations traditional understandings of sexuality and its relationship to the sacredness of life (Auger, J. 2005, p. 3). Traditionally, First Nations consider life as sacred and natural. Sexuality is viewed as an "expression of the life creating force between men and women" (Auger, J., 2005, p. 3). Over time, the life we knew began to change and so did sexuality. I refer to this change as a period of colonization and assimilation to a foreign way.

It is widely known that residential schools were a construct of the Canadian federal government's colonial policies coupled with the Church's practice aimed at the assimilation of Aboriginal people into the dominant society. The residential schools' sexual violence and abuse has been documented (Miller, 1996). In 2003, at the First National Indigenous Sexual Abuse Conference, Phil Lane, Jr. addressed this

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[17] In the context of this research the term Indigenous people refers to Canadian Aboriginal peoples, specifically to First Nations Cree and Métis peoples.

topic in his keynote address. He told a story about the most sacred of all ceremonies - the birth of a child. He stated that this ceremony has been neglected as a result of the interwoven complexities of widespread sexual abuse. He explained that sexual abuse, sexual abuse of children, incest, pornography, rape, child and adult prostitution, HIV/AIDS, and gang rape exist in our communities because "the creative power and sacred expression of life" has been abused (Lane, 2003). Unhealed sexual abuse and STI/HIV will continue to affect First Nations until holistic healing occurs.

Colonization and assimilation have affected our entire way of life to the point that Indigenous people need to re-learn their culture, language, spirituality, history, and traditions to help heal themselves, their families and communities. In a helical style, I introduce concepts spoken to me by elders and I interweave those thoughts by turning to a comparison of Euro-Canadian women, Indigenous women and Indigenous men living within a patriarchal Euro-Canadian environment. The comparison is to embrace diversity. Audre Lorde (1984) states:

> Difference must not [only] be tolerated, but seen as a fund of necessary polarities between which our creativity can spark like a dialectic. Only then does the necessity for interdependency become unthreatening…. Within the interdependence of mutual (nondominant) differences lies that security, which enables us to descend into the chaos of knowledge and return with true visions of our future, along with the concomitant power to effect those changes, which can bring that future into being…. As women we have been taught either to ignore our differences, or to view them as causes for separation and suspicion rather than as forces for change. Without community there is no liberation, only the most vulnerable and temporary armistice between an individual and her oppression. But community must not mean a shedding of our differences, not the pathetic pretence that these differences do not exist (Lorde, 1984, p. 111-112).

By acknowledging the differences I honour the uniqueness of Indigenous men and women.

Elders have said that when we are born to be Indigenous people it is for a reason and then they explain the Creation stories and connect us to Natural Law. These teachings are traditionally given to young people but because of colonization there are many people who now learn this information at an older age. It is through the use of sweetgrass and prayers from our ancestors and elders that we have maintained our First Nation culture[18] and tradition. Because we were born to be Indigenous, we are brought back to our cultural teachings wanting to know who we are as Indian people. It is then that we connect to our elders in the "Indian School" no matter what age we are.

Our First Nation culture[19] is meaningful and symbolic. When the elders connect us to our Creation stories and Natural Law they explain the cyclical nature of the life cycle from when we are born to when we become elders or great grandparents. They connect us to the stories about original man and original woman and how we as Indigenous people have spiritual blood and human blood. My purpose is not to reiterate everything I have heard but to connect those teachings to the importance of creation and identity. From the moment we are born into this world as Indigenous people, we have the responsibility to honour our cultural traditions and teachings. As Indigenous women, we have a gift to create life. From the moment we are born until we die, and thereafter, there is a continuum of ceremonies that respect the human and spiritual dimensions. As Indigenous peoples on this Earth walk we share a similar history and these experiences are discussed across generations.

Across time and space our culture[20] has changed. The written history of Canada encompasses trade and commerce, exploration, emergence of Métis people, wars over land, treaties, federal assimilation policies, residential schools, and the rise of an Aboriginal political movement from the 1960s and onwards. Like the Native Americans in the United States, the Indigenous people in Canada have also been affected, generation after generation, by "historical trauma" (Yellowhorse Brave Heart, 2004).

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[18] The words Indigenous and First Nation are used interchangeably to denote the original cultural connections to belief systems and a connection to the land.

[19] Merriam Webster's Collegiate Dictionary Tenth Edition defines culture as "the integrated pattern of human knowledge, belief, and behaviour that depends upon man's capacity for learning and transmitting knowledge to succeeding generations."

[20] The Public Health Agency of Canada (2007) defines the underlying premises of culture as "[s]ome persons or groups may face additional health risks due to a socio-economic environment, which is largely determined by dominant cultural values that contribute to the perpetuation of conditions such as marginalization, stigmatization, loss or devaluation of language and culture and lack of access to culturally appropriate health care and services."

Historical trauma is similar to Post Traumatic Stress Disorder [PTSD][21] but worse because it happens from generation to generation. This is why Indigenous people, who connect with their traditions, identify with their ancestors and elders because of the shared experience of life, history, and stigmatization that exists across generations.

Stigmatization of Indigenous women in the pages of Canadian history is rampant but now is being re-told through post-colonial and feminist lenses. Before I examine the Aboriginal women's experience of historical trauma across generations, I review some literature on the subjugation of my Euro-Canadian counterparts. Euro-Canadian women have also been oppressed based on gender and social class. I examine their experience as a point of departure to address the stigmatization of Indigenous women based on race, gender, and social class within Canadian law and society. I then turn my gaze to the literature that describes Indigenous men as silent in the face of historical trauma. Across time, the result of the colonization experience upon Indigenous peoples is a decline in the population, mainly as a result of many infectious diseases. Today AIDS threatens the population recovery of Aboriginal people. AIDS prevention is politicized. I examine the STI/HIV prevention efforts in Canada with respect to Aboriginal peoples to review the government and community efforts to address prevention of this highly politicized infectious disease. The action research and popular theatre efforts with respect to other social and health issues are presented in helical style.

European Patriarchy and the Subjugation of Women and Men

The subjugation of women in Canada reaches back to European laws and traditions. The Indigenous model of womanhood was shaped by Euro-Canadian laws. This is visible in Canadian law through the suffrage movement, Dower Law, the recognition of women as Canadian citizens under the law, and the Indian Act.

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[21] Shalev (2007) explains the etiology of PTSD as symptoms of a neuropsychological illness, that under traumatic circumstances one's protective shield is vulnerable to pressure (p. 208).

In the Laurier years (1896-1911), Canada lured immigrants to the Prairies with the promise of free land for all who were willing to homestead it – all, that is, who met the eligibility requirements. “Generally, women did not” meet the eligibility requirements (McCallum, 2004, p. 138). “More than two million people came to Canada between 1896 and 1911, many of them settling in the four western provinces” (Conrad & Finkel, 2006, p. 63). Women who came with their husbands to the prairies milked, baked, churned, fed hogs, raised chickens, and then handed over their money so that their husbands could buy more land (McCallum, 2004, p. 140). Marriage was viewed as a partnership but it was not a matter of choice nor one that was always gladly maintained but rather “the price one paid for a chance at economic security” (McCallum, 2004, p. 141). Women of higher social class were different from those who worked on the homesteads across the prairies. The women on the prairies had it worst. Women who moved out west thought they were protected by dower law[22] but were not. Euro-Canadian women had to contend with living in a ‘white man’s world’ because England’s legislation in 1833 had abolished the dower right in land so women moving to the prairies were not protected. These women were viewed as unpaid domestics and prairie drudges (McCallum, 2004, pp. 140-141). “By 1920 all three provincial legislatures (Alberta, Manitoba, Saskatchewan) had passed legislation addressing these demands in response to a public campaign for dower rights” (McCallum, 2004, p. 140). The prairie wives were not getting their fair share of land rights and benefits even though they worked their husband’s land. The Liberation movement of women in North America has been much stronger in North America than in Europe.

The demand for female suffrage started immediately following Confederation. The process of seeking suffrage was not respectful of other social classes within society. The suffragists expressed “unflattering views of the working class and immigrants, and frequently pointed to the injustice of allowing illiterate peasant men to vote while Canadian-born women were denied the franchise” (Conrad

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[22] According to McCallum (2004), “dower is the right of a widow to an interest for her life in one-third of the real property owned by her husband at any time during the marriage. Developed in England before the Norman Conquest, dower was a means to provide some economic security for wives in an age when married women did not have the legal capacity to own land, the principal source of wealth, and property owners did not have the legal power to dispose of their property by will” (p. 139).

& Finkel, 2006, pp. 147-148). In 1918, women won the right to vote federally (Conrad & Finkel, 2006, p. 183). According to Conrad & Finkel (2006):

> While women achieved little in the way of electoral representation in the 1920s, they made some progress towards political equality. In 1929, five Alberta women were instrumental in convincing the Judicial Committee of the Privy Council that women were "persons" under the law (p. 222).

Under the European model of treatment towards women, Indigenous women were subjected to worse treatment because of their race.

Regulations oppressing Indigenous women and their children based on their race and gender are found in the Indian Act. The Indian Act is considered paternalistic to Indian people who are considered to be 'wards of the state' requiring 'protection' (Fiske, 2006, p. 339). It has been widely accepted that the goal was to civilize Indians until they assimilated into broader society. According to Fiske (2006):

> From its beginning, the Indian Act embraced the patriarchal terms of the Enfranchisement Act of 1869, which stipulated that Indian women who married non-Indian men would have their and their children's legal status revoked. At the same upon marriage to a status man, a non-Indian woman became a status Indian and consequently benefited from federal Indian programs. Children whose mothers were status Indians but who lived off the reserve were also deemed status Indians. In 1941, however, the father's status came to determine the fate of children living away from the reserve. The act was amended again in 1951 to further disadvantage women; now any woman losing status through marriage also lost her band membership and her rights to reside on the reserve, to inherit reserve property, and to share in the band's resources (p. 340).

In those times, what was fair for a Native man and his non-Native wife was not fair for a Native woman and her non-Native husband. Furthermore, upon marriage a woman and her children were designated to obtain membership through her husband's band (Fiske, 2006, p. 340). If an Indigenous woman had children out of marriage her children would be registered with her band if the ministry approved (Fiske, 2006, p. 340). At a time when their Euro-Canadian counterparts had the right to vote and were recognized as Canadian citizens, Indigenous women in Canada were still subjugated to patriarchal rule. For instance, until 1951 Indigenous women could not attend a band meeting and could note vote in band elections (Fiske, 2006, p. 341). “Indian Affairs agents exercised considerable discretionary power over property inheritance. They allocated housing, agricultural land, and other valued resources to the benefit of men” (Fiske, 2006, p. 341). In 1985, after a long political struggle the efforts to redress the sexually discriminatory sections of the act were amended to conform to the Charter of Rights and Freedoms (1982) (Fiske, 2006, p. 341). The end result was that women and their children were allowed to be re-instated with a band and obtain Indian status (Fiske, 2006, p. 341). The First Nations communities are still addressing the effects of re-instating women and children within the political and economic realms.

The consequences that some First Nations people currently endure include landlessness, homelessness and overcrowding, loss of language, a lack of safe drinking water and nutritious food, unsafe communities, gang activity, addictions, unemployment and family breakdown. Living in these conditions prevents individuals, families and communities from developing a positive collective image and self-esteem. Without adequate housing and basic needs, many people are left with little choice but to relocate to the towns and cities, leaving any opportunity for practicing their land based culture or being able to contribute to the greater good of their First Nation. Leaving one’s own community leaves a feeling of disconnectedness to family, community and identity. Some First Nations people may not fit into mainstream society but feel marginalized while others adapt to a multicultural social milieu.

In Euro-Canadian society, marriages were viewed as a source of economic security for women. In these economic and legal unions, women were viewed as the subordinate partner. “Few today would argue that male dominance is or was universal” (Kelm & Townsend, 2006, p. 5). In contrast, prior to colonization Indigenous women were viewed as autonomous individuals in an egalitarian society. Indigenous women were viewed as equal partners and had the freedom to live in balance with their environment. Kelm and Townsend (2006) report:

> Most now accept that the majority of First Nations organized their gender roles around reciprocity and complementarity, but that there was considerable variation across space and over time. In the literature today, Aboriginal women are seldom labelled ‘powerful’ or ‘powerless’ (p. 5).

The literature suggests that Indigenous women were respected for their gender differences and not glorified nor demeaned. Since most First Nations valued reciprocity and complementarity between men and women; these values discourage the idea of having power over the other gender. The examples below reflect power exercised in the lives of some Indigenous women across time.

One noted example of Indigenous women's social position and power is reflected in their socio-economic role in the fur trade. Indigenous women were viewed as cultural mediators (Kelm & Townsend, 2006, p. 9). "Leading traders often married the daughters of Ojibwa leaders…a trader gained a powerful ally among his Indian customers" (White, 2006, p. 75). The trader formed kinship ties and he would provide for his Native wife's family in difficult times and, in turn, her kin would provide fur for trade. Marriage was a union not only between the man and woman but the extended family and trading company. Socialization within European society would have involved acceptance of the European customs and religions, however, acceptance of European values did not improve the status of Indigenous women.

The acceptance of the Christian faith is viewed as a contributor to the demise of Indigenous women's social position. The Jesuits adherence to patriarchy along with the subordination of women was an effort to civilize Indigenous peoples (Kelm & Townsend, 2006, p. 10). The acceptance of the Christian faith undermined the Indigenous female's role while the Indigenous male role strengthened (Kelm & Townsend, 2006, p. 10). In 1908, Indian Agents on the plains complained about the influence of women; Carter (2006) states:

> Reports of the superintendent general of Indian Affairs claimed that Indians raised dust with their dancing and the women's failure to clean it up spread diseases such as tuberculosis. Administrators blamed the high infant mortality rate upon the indifferent care of the mothers. The neglected children of these mothers grow up 'rebellious, sullen, disobedient and unthankful.' While men were blamed for the failure of agriculture, women were portrayed as resisting, resenting, and preventing any progress toward modernization. As an inspector of Indian agencies lamented in 1908, 'The women, here, as on nearly every reserve, are a hindrance to the advancement of the men. No sooner do the

> men earn some money than the women want to go and visit their relations on some other reserve, or else give a feast or dance to their friends…The majority of [women] are discontented, dirty, lazy and slovenly. (p. 150).

The history, as told from a colonialist's perspective, is full of value-laden judgements that demean the Indigenous woman. Perhaps the goal of Indian Affairs was to perpetuate the image of the European prairie woman as the submissive unpaid working drudge as a model for Indian women to conform to with no benefit of personal or family happiness.

With the arrival of the settler society, some Indigenous women married into the elite white society to discover that "race could trump class" and one might never quite fit in (Kelm & Townsend, 2006, p. 12). The patriarchal influence was strong in families where the father was British and the mother was Indigenous. Although Indigenous women brought valuable knowledge for trade and survival into their relationships, there was very little respect for the Indigenous race, as exemplified in Van Kirk (2006) who documents correspondence from Captain McNeill to George Simpson on March 5, 1851:

> My poor Wife…had been a good and faithful partner to me for twenty years and we had twelve children together…the deceased was a most kind mother to her children, and no Woman could have done her duty better, although an Indian (p. 175).

Race, gender, and social class were insurmountable barriers to acceptance of Indigenous women in colonial Canada. Assimilating into Euro-Canadian society meant leaving behind one's role in the Indigenous world during a time when disease was rampant and the social fabric of Indigenous cultures was in tatters.

The power and social status of pre-contact Aboriginal women has also been debated. The topics of debate are the connections between women's bodies, sexuality, colonialism, and power (Kelm & Townsend, 2006, p. 13). Kelm & Townsend (2006) state:

> Many First Nations cultures, for example, have traditionally equated the female body with Mother Earth or a similar unifying metaphor for Aboriginal physical and spiritual existence. Scholars also argue that the power and social status of pre-contact Aboriginal women emanated from their

> biological and reproductive roles, and that such 'mythological representations of traditional women's roles' continue to serve as an 'ideological basis for contemporary action.' Symbols of motherhood remain powerful and provided legitimacy to women's demands for change and justice within Aboriginal communities (p. 13).

This is in stark contrast to the ancient Greek view that some Europeans had adopted, whereby the female body is considered a symbol of inferiority, one that is submissive and passive (Kelm & Townsend, 2006, p. 13). Patriarchal colonialism has pointed the racist and sexist finger at Aboriginal women to create stigmatization.

Throughout time, there have been derogatory comments about Indigenous women. These comments reflect the bias of the writer who is usually a European male (Barman, 2006, p. 271). Barman (2006) defines the word sexuality from a sociological perspective as "the personal and interpersonal expression of those socially constructed qualities, desires, roles and identities which have to do with sexual behaviour and activity" (p. 271). In my opinion, the derogatory comments are meant to discourage racial acceptance to the point that there is a hatred for the other and an internalized hatred for oneself among some Indigenous woman, and internalized guilt among some Europeans for perpetuating stereotypes. I concur with Anderson (2000), who states that, the words "drunken squaw," "dirty Indian," "easy" and "lazy" are meant to trick and fool Canadian society about Native womanhood (p. 99).

As Taiaike Alfred (1999) states, "[w]ithout a good understanding of history, it is difficult to grasp how intense the European effort to destroy Indigenous nations has been, how strongly Native people have resisted, and how much we have recently recovered" (p. 1). The purpose of this chapter is not to delve into the history of our great warriors such as Tecumseh, Pontiac or Big Bear, but to reflect on the ramifications of the intense European effort to destroy Indigenous nations and to reflect on the impact of historical trauma as a way to focus on the silence of Indigenous men.

Population estimates demonstrate a post-contact decline but the purpose of establishing a baseline is to construct social histories (Waldram, Herring, & Young, 1995, p. 48). Depending on the estimates, the numbers can depict a catastrophic or gradual decline to exaggerate or minimize the depopulation of

Indigenous peoples. Various estimates have been provided as to the pre-contact North American Aboriginal population, ranging, from one million to eighteen million people (Young, 1994, p. 25). "However, it is generally accepted that the decrease in First Nations population was substantial after colonization of North America" (Cardinal, Schopflocher, Svenson, Morrison, & Laing, 2004. p. 15). In 2000, there were 112,792 First Nations peoples living in Alberta which is 4% of the population in Alberta (Cardinal et al., 2004, p. 8). Suffice it to say, warfare, infectious disease, and government assimilation policies have contributed to the complex story of the demise of North American Indigenous peoples. Whether it was catastrophic or gradual, Indigenous peoples lost almost all of their way of life. Although the numbers are showing some population recovery; recovering that way of life is more difficult.

Across time, the Indigenous man, who was once a powerful and respected orator and warrior, has become silent. It is a silence that speaks of the loss of power. Kim Anderson (2000) states that, colonial practices "stripped Native men of their autonomy and dignity, and robbed them of their ability to provide and protect" (p. 97). The historically traumatizing experience of having fought for their lands in the face of superior weaponry left them feeling powerless (Anderson, 2000, p. 97). Men and women watched as their children were taken away to residential school (Anderson, 2000, p. 97). Some of these men who watched their children being taken away had themselves experienced sexual, physical, mental, emotional and spiritual abuses. A native man who had been to a residential school in another province disclosed that, "they buggered with us." I can only imagine the shock, the feeling of utter loss of hope for the future knowing what their children were going to experience, too.

Across generations and over time, some of those children grew up to be men not knowing what their culturally-driven traditional role was, and as "cultural blanks" they were given "possession and control over their wives and children" (Littlebear, 2005, p. 11; Anderson, 2000, p. 97). Some of these Indigenous men felt helpless and frustrated and turned their feelings inward. As Anderson (2000) states, "[c]olonization in and of itself is a violent process" (p. 97). After turning their feelings inward, they turned their frustration and anger on someone weaker (Anderson, 2000, p. 97). First Nations women resorting to prostitution have been victims of historical trauma of colonization including child sexual abuse and other forms of abuse (Farley, Lynne & Cotton, 2005, pp. 254-261).

Evidence of violence can be found in Canadian prisons. As Waldram (1997) states, "Aboriginal men are over-represented in the Canadian correctional system" (p. 21). If prisons are a breeding grounds for HCV and HIV, there is an increased risk of transmitting HCV/HIV to the public because "few people stay incarcerated forever" (Collins, Dias, Dickenson, Lines & Vidovich, n.d.). Once the convicted person with either HCV or HIV has served his sentence and is released to an Aboriginal or non-Aboriginal community, his health becomes "issues of community health concern" (Collins et al., n.d., p. 4). Since Aboriginal men are over-represented in the Canadian correctional system, the immediate concern is population survival, health and wellness.

Some Aboriginal men have found healing. The picture that is painted is about identifying the root problems of STI/HIV. Our goal as Indigenous people is to survive and thrive in the era of AIDS as individuals, families, and communities by confronting and healing from the effects of historical trauma and its impact on our minds, bodies, and spirits for the betterment of infants/children, adolescents, adults and elders.

Population Recovery

Today, the First Nations and Canadian governments are trying to undo the damage from the tangled complexities of the past, with varying degrees of success. Still, life expectancy is substantially lower in the First Nations population than in the general population. Health Canada reports that, "In 2000, life expectancy at birth for the registered Indian population was estimated at 68.9 years for males and 76.6 years for females. This reflects differences of 7.4 years and 5.2 years, respectively, from the Canadian population's life expectancies" (Health Canada, n.d.).

In 2005, there were 458 600 First Nations[23] people residing on-reserve and 285 200 off-reserve (Leslie, 2008, p. 220, Treasury Board of Canada Secretariat 2005). In 2005, the majority of First Nations

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[23] First Nations refers to Status Indians

people (62%) lived on-reserve in one of the 614 communities across Canada. Most First Nations communities (61%) had fewer than 500 residents. The community where this research was conducted is one of Canada's larger First Nations communities with more than 2000 people living on-reserve. According to Leslie (2008):

> The on-reserve Status Indian is projected to increase by 53 percent from 2004 to 2021, compared with 11 percent for the Canadian population as a whole. It should be noted that 40 percent of the Status Indian population is under the age of 20, compared with 25 percent for the overall Canadian population. These demographic figures, coupled with generally poor living conditions on many reserves, demonstrate some of the socioeconomic challenges facing the Department (Treasury Board of Canada Secretariat 2005).

The socioeconomic problems will challenge young, single parents who are experiencing a baby boom. In Alberta, "First Nations females less than 20 years of age are 4.7 times more likely to give birth than females of the same age in the general population" (Cardinal et al., 2004, p. 10). In the era of AIDS, when one considers that high fertility rates are equal to unprotected sexual activity among this demographic of young First Nations people, there exists a potentially disastrous situation in the continuous spread of STI/HIV. When reviewed in a historical context, mortality from infectious diseases is not a new experience to Canada's Indigenous populations.

Since the late nineteenth and early twentieth centuries, a troubled relationship between the federal government and Indian people has existed. It has been an experience where the federal government has subsumed First Nations governance into a subordinate role and "gradually" given a Euro-Canadian model of authority to bands to control their local affairs with "ultimate governing authority" still resting with the Crown and its representative (Cassidy & Bish, 1989, p. 6).

Health services provided by the government to First Nations have been described as criminal (Titley, 1986, p. 85). In 1913, the Deputy Superintendent of Indian Affairs, Duncan Campbell Scott, advocated that the Indian agents, who had magisterial powers over First Nations, practice spending restraint and accountability. So, if the Indigenous people had infectious diseases and required health care, the Indian Agents could deny them under the guise of accountability and spending restraint (Titley, 1986, p. 83). Prior to Duncan Campbell Scott’s directive, infectious diseases existed in residential schools, contributing to high mortality rates (Titley, 1986, p. 83). The trend of ignorance and neglect existed prior to and after Duncan Campbell Scott’s reign despite the efforts of Dr. Bryce.

From 1903 and onwards, Dr. P.H. Bryce, the first medical officer for the Department of Indian Affairs, made it his life’s mission to increase the public’s awareness of the deaths of Indian children living in residential schools (Titley, 1986, p. 83). The deadly influence of a patriarchal government has cost the lives of Indian children. In 1922, a report was released denouncing the neglect of Native health as “a national crime” (Titley, 1986, p. 85).

Indigenous peoples’ lack of natural resistance to infectious disease has been buttressed with the idea that the pre-contact land and environment was similar to a Garden of Eden where Indigenous people lacked immunity to various pathogens (Waldram, Herring & Young, 1995, pp. 23-24). Waldram, Herring & Young (1995) identifies four reasons why infectious diseases became prominent among Indigenous peoples in Canada after colonization. They include contact with domestic animals, poor hygiene, overcrowding, and an increased population (p. 24). Virgin soil epidemics figured prominently in the post-contact history which resulted in high mortality (Waldram, Herring, & Young, 1995, p. 44). These are diseases originating in Europe to which the Indigenous population do not have immunity. They include smallpox, measles, influenza, dysentery, diphtheria, typhus, yellow fever, whooping cough, tuberculosis, syphilis, and other unidentifiable illnesses (Waldram, Herring, & Young, 1995, p. 44).

Smallpox is considered a depopulating epidemic (Waldram, Herring, & Young, 1995, p. 59). Smallpox could “survive for long periods of time on corpses and inanimate objects” (Waldram, Herring, & Young, 1995, p. 59). Smallpox has “a long period of infectivity…allowing it to move explosively and inexorably over huge distances” (Waldram, Herring, & Young, 1995, p. 59). To win the battle for North America in the Seven Years War (1756-1763), Lord Jeffrey Amherst, the commanding general of the British Forces enforced the “notorious recommendation” to intentionally distribute “smallpox-infected blankets” among the Indigenous peoples (Dickason, 2002, p. 159). Delaware prophet Neolin, warned his people to abstain from contact with whites, completely (Dickason, 2002, p. 159). Despite warnings, smallpox continued to spread from the United States into Canada and decimated populations that came into contact with whites. Samuel Hearne estimated that in 1781 smallpox decimated 90 percent of the Aboriginal population in Fort McMurray where the North West Company was located (Daniel, 1999, p.50). HIV/AIDS has the same potential to decimate a significant percentage of the population in Northern Alberta and elsewhere.

Politicizing Indigenous Health

Aboriginal people use both mainstream and their own culturally driven processes to prevent injuries and disease. In the era of AIDS, not having culturally driven prevention measures to alleviate the suffering of people exacerbates the achievement of sexual health. A “holistic” or “inclusive” population health approach is required. Given that our Cree culture is practiced in land-based settings, that connection to the knowledge keepers and land enhances the learning experience. Most STI/HIV prevention or health promotion activities for Aboriginal people are conducted without cultural, land based[24] activities. In traditional Indigenous communities the teachings about sexual and cultural identity occur in ceremonies that remind us of our connection to Creation; re-educating Indigenous people about the ceremonial process and teachings may involve a re-connection to the land. An example of this is the Rites of Passage Ceremony.

As Indigenous peoples, we know that health care services are only one factor that determines the health of a population. Health care services address the mind, body, and sometimes emotions of a person. Having a culturally based STI/HIV prevention program with a sexual health promotion focus would enhance services and programs for Indigenous people thereby alleviating the burden to the tertiary care provider by addressing the spiritual realm. If Indigenous traditional ways were utilized to enhance existing health services with respect to health promotion and disease prevention, the respect for the human and spiritual life would be profound and have everlasting impact. For instance, some Indigenous

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[24] Land-based activities are those activities that allow individuals to connect with their Indigenous spiritual identity away from the urban environment on the land with elders in ceremony.

people present offerings to elders for prayers for blessings for themselves and their loved ones to live healthy and safe lives. In this way, they are spiritually preventing harm from happening. The epistemology and ontology of First Nations culturally relevant health promotion and disease prevention practices are not applied in the dominant health care system, so implementing these methods in a comprehensive way continues to be a challenge unless more awareness and understanding occurs amongst all interested stakeholders.

Since First Nations people do not have complete control over decisions affecting their health and wellness on-reserve and much less off-reserve, it will be a long time before a comprehensive culturally-driven approach can be implemented. There needs to be more culturally relevant education about the significance and importance of ceremonies, between Indigenous communities and shared with the government and academia so it can be funded. In the meantime the ceremony is practiced secretively in some communities by a few people. Even though First Nations have governed themselves since time immemorial, the undermining efforts of colonialists have eroded the traditional forms of governance. Those traditional forms of governance have been subsumed beneath the dominant constitutional framework.

In Canada, the Department of Indian Affairs and Northern Development (DIAND) has a complex mandate to address First Nations and Inuit peoples "derived from the 1985 Department of Indian Affairs and Northern Development Act, the Indian Act, territorial acts, and legal obligations arising from section 91(24) of the Constitution Act, 1867" (Leslie, 2008, p. 220). Three major "business lines" include Indian and Inuit Affairs, Northern Affairs, and Departmental Management and Administration. The responsibilities of DIAND "encompass a wide range of services and overlap responsibilities with other federal departments (Leslie, 2008, p. 220). Leslie (2008) states:

> In 2004-2005, the Department's annual budget amounted to $5.9 billion. Within the federal government, Aboriginal programming[25] is shared among 14 federal departments and agencies with

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[25] The author does not state if this funding applies to Métis peoples.

> total expenditures of $8.8 billion. As of 1 April 2006, the Department had 3,839 employees, of whom 1,150 were Aboriginal (p. 220).

Despite the billions of dollars spent on Aboriginal programming, from land claims, Indian Affairs, corrections, education and health care, First Nations have little governing powers both on-reserve or off-reserve and they are compelled to follow government policies with respect to health service delivery unless they develop their own policies with approval from the department. The alternative is to practice their ways in segregation from the dominant system.

Health care in Canada for First Nations and Inuit people is unique. Most Canadians receive health care services through the 1867 British North America Act statute that outlines health care as a provincial responsibility, whereas Indians and lands reserved for Indians are considered a federal responsibility. Through treaty obligations, health care is considered a treaty right and First Nations consider the federal government as having a fiduciary responsibility to them. Sutherland and Fulton (1992) outline this complex delivery of health care services between the federal and provincial governments. The federal department maintains nursing stations, health stations, health centers, clinics and small hospitals (Sutherland & Fulton, 1992, p. 54). It provides a wide range of preventive, diagnostic, treatment and educational programs in the fields of dentistry, medical care, public health and environmental health (p. 54). The National Native Alcohol Drug Abuse Program (NNADAP) is a national program and offered locally in communities (p. 54).

While the federal government delivers programs and services to First Nations people living on-reserve, the services that a First Nations person uses off-reserve are part of the provincial health care system. The federal government has begun the process of transferring the delivery of health care services to the nation in which this field work was conducted but governance follows federal guidelines and policies with respect to health services as it is difficult to implement social/health policy from the bottom-up. In essence, the federal government controls health care services to First Nations people and some believe that First Nations people are part of a “third tier” of health care (Deagle, 1999, p. 247). In Canada’s northern Indigenous communities, health care policy is considered “imposed by an alien society" because it is "not to their community" (Thompson, 1993, p. 29). It lacks a vision of health based on Indigenous epistemology and ontology, still devolution of health care services to local band control has begun. In order to develop a holistic model of health, the nation utilized funding from the petroleum industry. Through a process of community engagement, the nation has an Indigenous model of health created by Habitat Health Impact Consulting funded by Shell Canada Energy Limited (Auger, Tamburrini, Orenstein & Lee, 2009). This is the first step towards developing holistic health services that may address STI/HIV prevention and treatment. Creatively utilizing outside resources enabled the nation to take a step towards delivering health services on their own terms. Developing policy to support the development of holistic health delivery and obtaining the resources to manage these programs are possible next steps towards governance.

There are two schools of thought on self-government. Some are in favour of self-government and others believe that the transfer would involve a "white bureaucratic system" that "would operate under existing funding" while "the real financial power would ultimately remain in the hands of the federal government" (Thompson, 1993, p. 30). From my perspective, utilizing traditional Indigenous health practices, coupled with mainstream healthcare, would enable community members to implement more resources that are culturally appropriate and suitable to address historical trauma.

Indigenous peoples have had devastating experiences with infectious diseases such as smallpox, tuberculosis, influenza, and, now, HIV and HCV. Gilley & Keesee, (2007) acknowledge that the oppression experienced by American Indians has led to a conspiracy theory "to explain the presence of HIV/AIDS within their communities" (Gilley & Keesee, 2007, p. 44). The dark history of oppression that was experienced over time calls for programs and services that focus on healing and reclaiming Indigenous culture, language, spirituality and traditions.

Recognizing the historical trauma across generations among Indigenous people, it is time to let go of the tears, heal, and rejoice in our survival. Words maybe easier than healing. Healing would require people to be ready to make changes within their individual lives and across their communities. As Taiaike Alfred (1999) states:

> The strength and quality of Indigenous peoples' greatest accomplishment is almost buried under the weight of the problems they confront. That accomplishment consists in their survival. Indigenous peoples have every right to celebrate their continued existence, and to draw strength from the fact that their nations live on despite the terrible losses of the past 500 years. Today's challenge must be shouldered proudly because it is no less than the sacred heritage passed on by generations of ancestors who sacrificed and died to preserve the notion of their being (p. 33).

The challenges are great. As I examined the cultural identity and roles of Indigenous men and women across time, I thought about our survival. As we try to ensure our survival through procreation and adhering to a respect for the life given us by our Creator, I realize that the ongoing effort for healing within Indigenous communities is needed. As Alfred (1999) states, "there is also a responsibility to rebuild the foundations of nationhood by recovering a holistic traditional philosophy, reconnecting with our spirituality and culture, and infusing our politics and relationships with traditional values" (pp. 35-36).

Saskatchewan Health (1999) recognizes that "various cultures provide a richness of ideas, knowledge and understandings" (p. 12). Furthermore, it recognizes that "knowing about cultures helps one understand the opportunities and challenges that each individual in those cultures has/had to deal with" (p. 12). Saskatchewan Health (1999) also recognizes that the growing Aboriginal population in urban and rural areas is working "together to rebuild their traditions and bring their strengths to the challenging problems they face" (p. 9). According to Goudreau (2006):

> Today, Aboriginal people are in the process of reviving their culture. In the field of health promotion, culture is considered a determinant of health. The Circle of Health, which is Prince Edward Island's Health Promotion Framework, has acknowledged that 'a rich cultural life is seen as a contributor to the health of a population, promotion of creativity and preserving tradition' (2006, p. 17).

In the era of AIDS, part of this challenge is to rebuild our nation's cultural identity and re-learn what it is to be an Indian man or an Indian woman. Understanding the historical, political, cultural, psychological and sociological factors that influence Aboriginal sexuality increases the need for culturally-relevant HIV prevention and health promotion programs among Aboriginal people in Canada. There is a spiritual aspect with holistic health and healing.

STI/HIV prevention using CBPR and popular theatre.

The field of public health sciences offers two possible approaches to HIV prevention. The two approaches focus either on the individual[26] or community-based prevention efforts. This research project was directed at a community by focusing on the stories shared by individuals.

The theoretical approaches to individual level change in reducing HIV risk behaviour focus on the human's mental capacity to affect physical change. From an Indigenous cultural perspective, the acknowledgement and understanding of Cree epistemology recognizing a spiritual aspect is non-existent. The spirit needs to be acknowledged to conduct culturally appropriate Indigenous prevention and health promotion programs which focus on the individual. In our Cree culture, a preventative approach involves prayer and belief in the strength of the prayers because the power of the mind influences our being. Change at an individual level can sometimes prompt families, communities and the leaders of nations to make social/health change.

My research focused on the real stories that individuals shared in group, along with the fictionalized stories the group created for the community performance. During the process of action research and popular theatre the group became spiritually aware through interacting with me and the elders. Our work impacted the community and this is discussed in Chapter Eight.

Diffusion Theory is a theoretical approach for addressing community-level change. According to Everett Rogers, "Diffusion is the process through which an innovation, defined as an idea perceived as new, spreads via certain communication channels over time among the members of a social system" (Rogers, 2000, p. 57). "When the acquired immunodeficiency syndrome (AIDS) epidemic was detected in

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[26] The models are the Health Belief Model, AIDS Risk Reduction Model, Transtheoretical Model, Social Cognitive Theory, Theory of Reasoned Action, Theory of Planned Behaviour and Information-Motivation-Behaviour Skills Model (Fisher & Fisher, 2000).

1981, the diffusion model was used in designing HIV prevention programs" (Rogers, 2000, p. 57). This model had been used in part "on epidemiological models of the spread of an infectious disease" but was also used in family planning programs, preventive health campaigns and other health improvement interventions (Rogers, 2000, p. 57). Rogers (2000) describes three strategies of applied diffusion theory and they include an epidemiology investigation, investigation of programs targeting specific populations, and a quasi-experiment on the effects of an education radio soap opera in Tanzania aimed at reducing the spread of the virus (p. 58).

From a public health and Indigenous cultural perspective from which I speak, focusing on social change that includes family and community groups is culturally appropriate. I believe that significant change happens when the nation enacts social/health change to impact the community, family and individuals across the lifespan. Ultimately, leadership must enact culturally appropriate healthy public policy for social/health change in Indigenous communities. Furthermore, public health[27] ought to acknowledge the belief systems of Indigenous peoples through understanding, designing, and implementing culturally appropriate programs. This includes acknowledging and understanding that in order for every man, woman and child to maximize their potential they must have a connection to Mother Earth.

The historical experience of Aboriginal people in Canada has not been fully rectified, as people continue to: live with a reduced land base; recover traditional teachings and lifestyle practices; find affordable housing and alleviate overcrowded conditions; resolve food-security issues; cope and heal from intergenerational trauma learned across generations from the residential schools; become culturally aware; and find belonging and acceptance within a cultural group.

Culturally appropriate STI/HIV prevention programs at the community level should focus on adolescents so they can practice what they learn across their lifespan. Using a cultural approach might involve using the Cree rites of passage ceremony as an opportune time to teach young people about their

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[27] Public health programs include population health, disease and injury prevention, health surveillance, and health promotion.

role in preventing STI/HIV. My view is that life is created through sexual expressions that are viewed as both sacred and natural to Indigenous people (Auger, J., 2005, p. 2). Nobody should die from a basic physiological need and therefore STI/HIV prevention is vital to our survival. If young people are taught their role in preventing STI/HIV through a rites of passage ceremony then our chances of survival are greater. Although not all Cree people are aware of this ceremony, the role of health programs should be to support this knowledge base for cultural continuity. Further research on rites of passage ceremonies for First Nations, Inuit, and Métis populations are required in order to support and implement this means of introducing culturally appropriate STI/HIV prevention. CBPR offers an approach to further inquiry.

Public health has recently embraced community-based participatory research even though there are numerous variations of the term. These versions “vary in goals and change theories,” but there is a set of core principles and values (Minkler & Wallerstein, 2003, p. 5). The core principles and values of CBPR are that:

1. It is participatory.
2. It is cooperative, engaging community members and researchers in a joint process in which both contribute equally.
3. It is a co-learning process.
4. It involves systems development and local community capacity building.
5. It is an empowering process through which participants can increase control over their lives.
6. It achieves a balance between research and action.

“[S]cholars of colour and feminist participatory researchers” suggest that issues of gender, race, class and culture be included (Minkler & Wallerstein, 2003). The acceptance of the term community-based participatory research in public health sciences has been due to the ongoing existence of health and social problems like HIV/AIDS and ill suited traditional “outside expert” approaches (Minkler & Wallerstein, 2003, p. 3). First Nation researcher, Verna St. Denis has worked to define CBPR and states that it is “more responsive” to the needs of our communities and “disempowered communities” than other social science research methods (St. Denis, 1992, p. 51). My research fulfilled most aspects of CBPR as defined by Minkler and Wallerstein (2003), with two exceptions: 1) I wrote a proposal and received ethical approval from the University of Alberta as I did not have a community group to consult with but my ties to the community seemed to address this core principle; 2) it is not known whether my published research will contribute to developing a "system" to address culturally appropriate STI/HIV prevention for Indigenous populations.

When I started this research I worked from a broad action research orientation. I found that there were as many definitions and types of action research.[28] Action research is not "conventional social scientific research" intent on description and analysis to explain phenomena (Abercrombie, Hill, & Turner, 1988, p. 2). The role of the researcher is not to be "detached, in order to minimize disturbance of the phenomena under investigation" (Abercrombie et al., 1988, p. 2). Action research is involved and interventionist (Abercrombie et al., 1988, p. 2).

According to Kurt Lewin, its originator, action research requires repeated series of cycles of social planning, reconnaissance, review, and replanning (Adelman, 1993). Action research is a "systemic inquiry that is collective, collaborative, self-reflective, critical and undertaken by participants in the inquiry" (McCutcheon, & Jung, 1990, p. 148). It is not a method but part of the CBPR "orientation" (Minkler & Wallerstein, 2003, p. 4). Three requirements of action research[29] are: that "the subject matter must be a social practice; it must proceed through a self-reflective spiralling cycle of planning, acting, observing and reflecting; and it must involve collaboration with those in practice and those affected by practice" (St. Denis, 1992, p. 54). The role of the researcher is to collaborate with the 'subjects' in a research process that is "collaborative and democratic" (Richardson, 2002). In my research, I worked with a group of young people and elders towards prevention of STI/HIV. In doing so, I fulfilled these expectations.

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[29] St. Denis builds on the work of Grundy, 1982; Carr and Kemmis 1986; Peters and Robinson, 1984.

Grundy (1988) identifies three types of action research: technical, practical, and emancipatory (Masters, 1995). Emancipatory action research is also known as critical action research, or research conducted from a critical science perspective (Grundy, 1988, Holter & Schwartz-Barcott, 1993; McCutcheon, & Jung, 1990; McKernan, 1991). In critical action research the researcher has two goals: the first goal is to "increase the closeness between the actual problems encountered by practitioners in a specific setting and the theory used to explain and resolve the problem … [and] to assist practitioners in identifying and making explicit fundamental problems by raising their collective consciousness" (Holter et al., 1993; Masters, 1995). According to Habermas, the goal is to create "critical communities" in order to change consciousness among minorities and marginalized groups who experience domination and control (Morrow, 1994). Technical action research focuses on producing a product whereby the researcher is the expert and a technician carries out the plan with a group of willing participants who will make or create something (Grundy, 1988, p. 355). Practical action research utilizes the knowledge and wisdom of the researcher to help guide in the best interests of the participants (Grundy, 1988, p. 357). The researcher could be assisted by a facilitator who helps with self-reflection and reasoning (Grundy, 1988, p. 357).

The goal of critical action research is to emancipate the participants from the "dictates of compulsions of tradition, habit, coercion, as well as from self-deception" (Grundy, 1988, p. 358). Theory, enlightenment and action move towards social change (Grundy, 1988, p. 358). Grundy refers to Michael Polanyi's concept of 'personal knowledge' where knowledge becomes part of our being (p. 359). By interacting theory with personal knowledge a process of reflection occurs amongst all participants (pp. 359-360). The goal of emancipatory action research is enlightenment amongst all participants. Critical theory or emancipatory research is focused on developing knowledge for improving and transforming social reality (St. Denis, 1992, p. 54).

My goal was to encourage the young people participating in the popular theatre/action research process and those watching the drama production, to begin critically thinking about the issues around STI/HIV prevention and to take action to prevent it. However, my research aligned closely with practical action research mainly because of the restricted ten-week time frame and the group members choosing[30] to conduct one community performance instead of four. These two factors prevented a development of critical thought processes necessary for emancipation which in the case of Aboriginal people implies freedom from paternal control and responsibility of Church and state. Creating awareness for emancipation is time-consuming. Nevertheless this research took a step in this process, and was successful because it was a holistic learning experience.

According to Sumara and Carson (1997) action research is holistic. Borgmann identifies the importance of establishing a focal reality through the encounters each of us has when we engage in mind and body as we center our lives, which could be through gardening, art, caring for animals, and, I would advance, popular theatre. Having a focal reality means that one’s sense of identity and daily practices are interpreted in relation to one another. Maintaining a focal reality situates the person in holistic practices where “skill and knowledge emerge from processes of accomplishing particular tasks,” and “the coemergence of form and content,” is acknowledged (Sumara & Carson, 1997, p. xv).

Sumara and Carson (1997) posit that writing stories about action research is “particular,” as are my own lived experiences which are “configured” in specific ways that include my beliefs, philosophies, attitudes about research practices and the relational organization of my living conditions. In the context of writing the results for this research, my voice, as the author, is central and therefore this dissertation focuses as much on the connections between the researcher and the subject as the outcomes for the purpose of generating new knowledge (Sumara & Carson, 1997). The use of the Indigenous Iterative Webbed Circle allows the writer’s voice to emerge while connecting the parts to the whole.

The process of action research involves living a life that allows one to perceive differently, to avoid what Said describes as, living a life like a habit of expression that preserves the status quo (Sumara & Carson, 1997). It is living life out of your comfort zone. Living life at the edge and removing oneself from comfortable habits remove me from the familiar. Working on this project required living life at the

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[30] The decision to perform once is described in Chapter Four.

edge and achieving a holistic focal reality that developed into stories using the values of the Indigenous Iterative Webbed Circle

Community Based Participatory Research is an increasingly used method. For example, the gay community in Vancouver, Canada, rallied to support community based research at a time when people were reacting to AIDS (Trussler & Marchand, 2005). The potential for this research had to be demonstrated, so the largest AIDS organization in Vancouver was engaged to define the purpose of 'health promotion' in AIDS work; researchers conducted a qualitative study of the organization's working conditions (p. 45). The research showed that to improve human situations the organization must build on the skills, knowledge and competencies of those doing the work. The research in Vancouver encourages critical reflection for the community's benefit (p. 46). Essentially, community based research "is in such demand because it concerns shared learning from direct experience" (p. 52).

CBPR was also used for STI/HIV prevention activities among Aboriginal populations. Community-based participatory research (CBPR) evolved as an effective research paradigm to make research more inclusive and democratic by fostering the development of partnerships between communities and academics to address community-relevant research priorities (Flicker, Travers, Guta, McDonald, & Meagher, 2007). Participatory action research has been conducted to inform policy and create evidence-based prevention programs. For example, a participatory action research project was conducted in Vancouver with survival sex-trade workers that included Aboriginal women. The results showed that there is "a clear lack of policy and interventions tailored to promoting the health and safety of substance-using women working in survival sex work" (Shannon, Bright, Allinott, Alexson, Gibson, & Tyndall, 2007). The purpose was "to inform evidence based prevention and policy reforms" (Shannon, et al., 2007). The recommendations of CBPR reports help to create some awareness of the challenges facing policy makers who attempt to address the problems facing survival sex-trade workers. I would advance that policy makers should implement culturally driven interventions to help defeat addictions and historical trauma, thereby promoting healthy sexuality and cultural identity among Aboriginal females, because the results of colonization have had "disastrous consequences for First Nations women, with astronomical rates of incest, rape and husband violence" (Farley, Lynne, & Cotton, 2005, p. 258). In Ontario, researchers employed the "train-the-trainer method and culture-sensitive instructional manuals" to deliver an educational workshop on HIV/AIDS to a group of Aboriginal adolescents (Majumdar, Chambers, & Roberts, 2004, p. 69). The researchers in this study used the CBPR orientation and created a support group for the youth. While the study supports culturally sensitive interventions, the researchers state that "high risk behaviours are related to more complex emotional issues that are often overlooked by current prevention efforts" (Majumdar, Chambers, & Roberts, J., 2004, p. 72).

The sexual issues of STI/HIV prevention are complex given the historical, political, cultural, social and psychological factors. Community based participatory research is responsive to the needs of First Nations communities because it gives us opportunities to voice these issues to social scientists. In turn, social scientists utilizing action research can help develop policy to prompt social change for and with First Nations.

In my iteration of the literature and research I advocate for the development of more culturally appropriate STI/HIV prevention for Indigenous peoples. Given that Indigenous peoples are sexually active across the life span, I posit that a culturally-driven land-based educational approach must be implemented across all age groups (First Nations Center, 2005, p. 76). The purpose would be to re-educate our people about the importance of land, language, cultural values and practices in order to enhance one's identity and prompt wiser choices across the life span.

The Blackfoot teaching on Maslow's Hierarchy of Needs is similar to Cree teachings in that by connecting to Mother Earth one's being is strengthened. A land based cultural program involves connecting to Mother Earth through an exploration of Indigenous science and spirituality. The purpose is to respect creation and to maintain balance and harmony for our health and wellbeing. One then finds security and safety with other people and the environment. This leads to a sense of connection and belonging, whereby people feel respected, supported and loved. From this position one then becomes a self-actualized human being. Thus having a land based cultural program is important for human development. I take this position because knowing one's role within one's culture helps provide the guidance a young person needs. By knowing one's cultural role, language, and values, a young woman or young man could maintain their cultural teachings across the lifespan. People can prevent STI/HIV through culturally appropriate teachings and public health methods. Elders and knowledge keepers can connect Aboriginal youth to the land through rites of passage ceremonies and other cultural activities while emphasizing the importance of the First Nations belief system with respect to the land, language, culture to promote awareness of STI/HIV prevention and health promotion.

Condoms can prevent STI/HIV. "Condom use has been strongly advocated as a means of STI/HIV prevention, and yet, across all age groups, they (Aboriginal people) stated that they do not always use condoms citing the main reason as having a steady partner" (First Nations Center, 2005, p. 76 -77). The spread of STI/HIV could occur if a partner is unfaithful or if a person practices serial monogamy, having one relationship after another. Cultural teachings about respect for one's body and others would help prevent STI/HIV along with consistent condom use.

Most STI/HIV prevention programs are not designed to encourage Indigenous people to think critically about the epistemology of healthy Indigenous sexuality based on their cultural identity and gender roles. Allowing room for critical thought based on contrasting mainstream and Indigenous values of sexuality is essential to begin emancipating Indigenous people, from the trauma of unhealthy sexuality.

Currently, it is up to an Indigenous individual to learn about their culture on their own because these teachings are not taught within educational or health institutions. Unless individuals know and understand their cultural teachings there is no room to critique mainstream values regarding sexuality against their own.

Most programs advocate for an approach that includes condom use and STI/HIV testing (SERC Manitoba, 2008, AIDS Vancouver, 2008, Alberta Health and Wellness, 2004). As well, condoms continue to be promoted in prisons (Nerenberg, 2002). Blood testing for STI/HIV continues among the Aboriginal population and/or drug using population in inner cities or First Nations reserves (British Columbia Center for Disease Control in partnership with the National Film Board of Canada, 2007). While condoms are an important primary prevention technology, in cases of sexual activity that is non-consensual, coerced or transactional, condom use may be limited or non-existent. These programs are important but so is critically thinking about Indigenous sexual health. There are many ways to learn.

The internet is a resource to the STI/HIV prevention effort focusing on Aboriginal people in Canada. The Ajunnginiq (Inuit) Center at the National Aboriginal Health Organization (2008) offers an online resource entitled, “Sexual Health: Resources for Inuit and Aboriginal peoples in Canada.” It is a ‘living document’ comprised of literature that “aims to provide readers with a listing of some of the research, studies, public health information and health promotion materials that exist on Inuit, Aboriginal and Indigenous sexual health” (Ajunnginiq Inuit Center at the National Aboriginal Health Organization, 2008).

Some STI/HIV prevention projects have adopted a holistic traditional philosophy to reconnecting Indigenous people to their spirituality and culture. This approach supports Taiaike Alfred’s call for reclaiming cultural identity and I would add that it is important to critique the Indigenous view of healthy sexuality with a mainstream view. The Sexual Education Resource Center [SERC] in Manitoba recognized that issues related to sexual and reproductive health in the Aboriginal community are compounded by the effects of colonization, poverty, and marginalization. As a response to those issues, White Wolf Speaking is a program determined by the Aboriginal community to develop culturally appropriate sexual reproductive health resources and materials (SERC, 2008). The White Wolf Speaking initiative involves elders and community members in a project to educate and inform Aboriginal women with an emphasis on younger women “exploited in the sex trade” and youth (SERC, 2008). “White Wolf Speaking serves to support SERCs capacity to develop, design and deliver culturally appropriate sexuality and reproductive health (SRH) education and services, through consultation and partnerships with the Aboriginal community” (SERC, 2008).

Other programs also address STI/HIV prevention by utilizing Aboriginal people to inform other Aboriginal people about STI/HIV prevention, but it is not clear whether a holistic traditional philosophy is inherent in these approaches (British Columbia Center for Disease Control, 2007). Some public health campaigns are more creative than others. For example, one utilized the talents of Aboriginal youth to create a film and video game to discuss choices (British Columbia Center for Disease Control, 2007). Another program utilized puppets to inform Aboriginal people about their experiences with HIV/AIDS, thereby raising awareness (Interagency Coalition on AIDS and Development, 2002-2003). Children are a target audience for a book entitled, “The Gathering Tree,” considered a prevention and awareness resource (British Columbia Center for Disease Control, 2005). “Bevel Up: Drugs, Users and Outreach Nursing,” is an education kit that includes a DVD and teaching guide on a street nurse program; the street nurse program has a provincial mandate to offer prevention programs focusing on harm reduction and includes blood testing (British Columbia Center for Disease Control in partnership with the National Film Board of Canada, 2007). In addition, annual HIV/AIDS walks promote awareness (Red Road HIV/AIDS Network, 2008).

When I started thinking about STI/HIV prevention in my own Indigenous community, I thought of my conversations with Ken Ward. He said that one has to touch hearts in order to prevent HIV (personal communication, 1996). From my perspective, popular theatre and action research offered a unique framework to enable the people who I would work with to assess the personal risk factors and conditions of risk for STI/HIV by creating plays that their community members can relate to. Given Ken Ward’s words to me, that HIV prevention was about “breaking barriers and healing hearts,” I considered popular theatre and action research to be strategies that should be implemented and examined (personal communication, 1996).

Popular theatre is known by another term. The term ‘applied theatre’ is related to what has often been called ‘popular theatre’. According to Prentki & Preston (2008) there are a number of terms under the umbrella term ‘applied theatre,’ including ‘popular theatre’ (p. 9). Applied theatre is conducted for “social and community change” or to “reveal the hidden stories of a community” (Prentki & Preston, 2008, p. 9). Essentially, applied theatre has emerged in recent years as a term describing a broad set of theatrical practices and creative processes that take participants and audiences beyond the scope of conventional, mainstream theatre into the realm of a theatre that is responsible to ordinary people and their stories, local settings and priorities (Prentki & Preston, 2008, p. 9).

Popular theatre can serve as a medium for participatory [action] research (Kidd & Byram, 1979). The authors note that the methodology is manageable for community members (Kidd & Byram, 1979). I would add that it is possible for community members to manage and deliver their own theatre programs to promote awareness of social and health issues. Popular theatre creates awareness of people's own resources and mobilizes them (Kidd & Byram, 1979). It provides continuity in the definition, analysis and solution to a community's problems (Kidd & Byram, 1979). Popular theatre is entertaining and it holds the community interest (Kidd & Byram, 1979). The researcher is a committed participant and learner (Kidd & Byram, 1979). It links 'the heart' (emotion) with knowledge and information and allows for examination of issues to be placed in contexts which are familiar and meaningful to particular community audiences. Popular theatre fosters cooperative thinking and action (Kidd & Byram, 1979). Through popular theatre, community members share in a public examination of an issue or event and can communally engage in a post-theatre discussion (Kidd & Byram, 1979). Applied theatre can be performed in "informal spaces" that include a variety of "geographical and social settings" (Kidd & Byram, 1979, p. 9). It resonates with the participants and audience members (Kidd & Byram, 1979, p. 9). Popular theatre includes community members and this is strikingly different from professional theatre companies who hire professional actors.

Professional theatre companies have staged plays about HIV and AIDS since 1991; however, little published information is available (McEwan, Bhopal, & Patton, 1991). "Body Talk" is the title of a play and workshop addressing HIV and AIDS, and to evaluate the program "surveys and a focused group discussion were undertaken in schools" (McEwan, Bhopal, & Patton, 1991). The results of the evaluation with students determined that after watching the show their knowledge level was the same, however their attitudes changed: students recognized that it was the responsibility of both sexes to discuss contraception, pressures, and change behaviours however the program had little effect on whether or not more students would use condoms. After watching the play; the same number of people stated they would discuss AIDS before having sex. After watching the play there was an eighteen percent increase in anxiety levels among students who had watched the play. After participating in the program the students stated they enjoyed the theatre and workshops as a method of presenting health education.

"Someone Like You" is a thirty-minute play that was performed by the Women in Theatre Group for fourteen year-old school children who attended the Nottinghamshire secondary school (Denman, Pearson, Moody, Davis & Madeley, 1995, pp. 3-17). After the play, thirty students participated in a one and a half hour long workshop. It was another health education effort that involved obtaining surveys from the students before and after watching the play. Two hundred and fifty-two students were in the experimental group and four hundred and twenty-eight students were in the control group. All the students in school had learned about HIV and AIDS through the education curriculum and they knew about transmission and risk factors. After watching the play, the experimental group showed significant gains in knowledge, greater shifts towards positive attitudes regarding HIV-positive children, maintaining confidentiality, and using condoms.

A study measuring the effects of a theatre production on HIV knowledge, attitudes and risk behaviour of young people was conducted in socially-deprived areas of Glasgow (Elliott & Gruer, 1996, p. 1). This study shows that theatre in AIDS education does not significantly impact HIV knowledge, attitudes and risk behaviour (Elliott & Gruer, 1996, p. 1).

A one-hour long theatre performance by CAMP Teen theatre for Latino youth increased their knowledge about STI and HIV, to promote abstinence and postpone sex (Guzman, Cassad, Schlehofer-Sutton, Villaneuva, & Feria, 2003). The cast was Latino and they were given forty-eight hours of training on STIs, HIV/AIDS, teenage pregnancy and other sexual health concerns. In the one-hour long theatre production twelve different, but related, skits were performed. Before watching the play a pre-test questionnaire was administered. After the play the participants discussed the topic for fifteen minutes. A post-test questionnaire followed. "Results indicated that the intervention increased participants' reported intentions to delay sex and use contraceptives" (Guzman et al., 2003, p. 269).

Popular theatre and action research have been used in other social, health and cultural contexts. "Are We There Yet?" [AWTY] is a participatory play written by Jane Heather, who also worked on my project in 2005. This play's creation was informed by participatory research processes and takes a highly interactive approach. Developed in 1998, the sexuality education play is followed by a workshop for young people between fourteen and sixteen years of age (AWTY Community University Research Alliance, n.d.). Currently, a Community University Research Alliance (CURA) is assessing the strength and value of "theatre in community and educational programming, with particular emphasis on participatory theatre processes and forms" (AWTY Community University Research Alliance, n.d.). Created by Jane Heather, this play is essentially for the mainstream population and not Aboriginal youth specifically, however the CURA team partnered with the Saskatchewan Native Theatre Company to adapt the play and program for use in Saskatchewan Aboriginal communities.

Since 1981, Planned Parenthood has produced theatre projects in Canada in both official languages, French and English (Planned Parenthood, 2007). Planned Parenthood has been using a peer education theatre approach to entertain and educate youth since 1998, and strives to provide accurate information about healthy decisions regarding sexuality. This program coaches youth in drama and improvisation as they learn about sexual health issues (Planned Parenthood, 2007).

In 2005, Diane Conrad published an article about working with 'at-risk' youth that included young Aboriginal people in a Northern Alberta rural community. Conrad produced a popular theatre play entitled "The Bus Trip" where issues of alcohol misuse were examined (Conrad, n.d.). Although the play examined the role of geographical location and boredom leading to alcohol use, it did not address STI/HIV prevention. It seems that alcohol misuse is a common theme among young Aboriginal people living in Northern Alberta. It was a theme in my research as well, whereby young people explored how drunk and high sex factors into the spread of STI/HIV.

Chapter Three: An Action Research and Popular Theatre Project

As Part of the Indigenous Iterative Webbed Circle

The focus of this chapter is to provide the rationale for my study design. The design reflects my beliefs that are grounded in literature, observation and cultural knowledge about STI/HIV prevention and it requires examining this health issue from a political, historical, cultural, psychological, and social perspective. In this chapter, I discuss in what ways action research and popular theatre are conceptually, methodologically, and culturally appropriate for addressing STI/HIV prevention in an Indigenous community. I introduce Grandmother Spider and the Indigenous Iterative Webbed Circle. The information is presented helically, where I mention a concept and return to it later in the chapter. I weave together the principles of methodology of action research and popular theatre followed by an explanation of the methods of data collection.

Originally, when I submitted my proposal to the Faculty of Medicine and Dentistry and subsequently to the Health Research Ethics Board Panel B for approval, I stated that this research design would use action research and popular theatre as an intervention to prevent the spread of STI/HIV. This intervention involved working with a popular theatre practitioner and young Indigenous people who would be supported by a group of elders. The young people would investigate the issue from their perspective and develop a play to perform for their community and deliver a message about STI/HIV prevention. In pursuing ways to meaningfully analyze the results, I created the Indigenous Iterative Webbed Circle to present the findings while creating new knowledge.

The purpose of the research project was to explore whether or not action research and popular theatre were effective methods for developing STI/HIV prevention. One of the important aspects of this study design was that it was conceptualized with an Indigenous approach to the research always in the back of my mind. I framed my one to one interviews on aspects of the Ontario Aboriginal Health Policy. Specifically, I asked the youth what impact their involvement in this project would have on themselves, their family members and the community. I also invited elders to participate, held talking circles, and planned for smudging ceremonies. Since I believed that intergenerational trauma reaching back to the residential schools was affecting the identity and sexuality of young Indigenous people today, I felt that creating time and space to allow for elders and young people to connect and share stories would help the young people understand what their elders have experienced through the residential schools, thus helping them to understand how the past affects the present. Having an open and flexible study design allowed me to follow the guidance and wisdom of the core group of young adults and secondary group of elders so that we could take "action" towards affirming Indigenous identity and addressing the STI/HIV health issue through popular theatre and our culture.

My assumptions underpin the study design include discussion of the political, historical, cultural, psychological, and social aspects affecting Indigenous sexuality which underpin the social determinants of health. This research addresses whether or not the process and methods, elders, and popular theatre practitioner, can help effect health and social change within the group and community audience.

Entering the Discourse on Participatory Consciousness

The Indigenous Iterative Webbed Circle encourages reflection on the participatory process. The model was designed to frame and assess my research data and allow the opportunity to make meaning of the stories about STI/HIV prevention using action research and popular theatre in an Indigenous community according to the cultural values of kindness, honesty, caring and strength that are inherent in my culture and other cultures. Analyzing the data according to these values allows me to use tell a story from the emic, or insider, and first person perspective. By doing so, the narrative supports the utility of popular theatre and action research. These cultural values of kindness, honesty, caring and strength are used to reiterate the lessons that were learned from conducting research in the field. In addition to telling the story, I provide a response to the research questions. By analyzing the data within my own cultural framework I found my voice and created ethical space that allows for greater understanding of Indigenous ways of knowing. I have developed this as a new model[31] to help others develop new forms of knowledge or theories (Kulchyski, 2000; Guba & Lincoln, 1994).

Although quantification, measurement, and linearity are associated with the Western scientific paradigm, many other fields promote a wider understanding of humans and society. Indigenous scholars are advancing the need for decolonization and reaffirming the voice of the author in research to promote a clearer understanding of humans and society. Below are some examples of what Indigenous scholars say about the importance of decolonization, creating "ethical space," and story-telling.

Linda Tuhiwai Smith, Maori scholar, identifies problems that have risen in the Indigenous "struggle for humanity" that involves overthrowing the ideologies relating to Indigenous peoples' supposed lack of humanity (1999, p. 26). She postulates that there is a binary between the colonized and the colonizer and it is not a simple opposition but several relations that are interlocked in opposition (Smith, 1999, p. 27). I posit that many of the historical consequences that we as humanity are now left with, due to the relationships between our ancestors, have left an unhealed bitterness, as one tried to strip the other of its dignity, and we all share a responsibility to restore that dignity.

Ermine's solution to restoring dignity is to create ethical space (Ermine, 2005, p. 1). Ermine builds upon Poole's (1972) idea of ethical space by defining it as a process whereby Indigenous people use their "languages, worldviews, and community aspirations for an ethical order in society" instead of "relinquishing one's language and culture in order to participate in the mainstream," (Ermine, 2005, p. 5; Bishop, 1994, p. 177). Using Denzin and Lincoln's (2000) position, Ermine pushes away from the grand or master narrative to find equal footing for the idea of a "sacred space for human advancement," as a place where Indigenous people, the "oppressed or silenced voices can enter the discourse" (2005, p. 5). He identifies the challenge:

> This means work to reconcile a scientific based knowledge that defines much of the Western world with an epistemology based on participatory consciousness and personal experiences with human,

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[31] The Indigenous Iterative Webbed Circle is a dreamcatcher with traditional values and concepts.

> natural, and supernatural relationships found in Indigenous learning traditions. It will mean resolving issues of knowledge like ownership, control, benefits and all the other assorted contested issues endemic to the current research order. Inevitably, we come to the realization that the ethics of research are all about empowerment (Ermine, 2005, p.5).

Ethical space is about “developing knowledge systems that have been endangered by years of colonial domination” (Ermine, 2005, p. 5). While it is important to think of research as a practice towards creating ethical space and developing knowledge systems, it is also important to think about how research is portrayed and shared within academia. Through this project, the co-researchers developed a play whereby their voices speak about stigma, sexual expression and dealing with social/health change in the era of AIDS. Through theatre the voices of oppression find an empowering venue. In the humanities, Indigenous scholars are providing commentary on embracing the way in which Indigenous people tell stories as opposed to trying to conform to a classic Western paradigm.

Indigenous knowledge is being regenerated in academia. Indigenous people who are accustomed to passing information from generation to generation via the oral tradition are weaving stories through the written word to create awareness of cultures and language as a means of revitalizing knowledge systems so that there is a “greater understanding of humans and human society” (Blaeser, 1997, p. 11). Blaeser refers to Leslie Silko’s reference to a spider’s web as a structure of Pueblo expression, in “Language and Literature from a Pueblo Indian Perspective,” through which meaning is made with no preordained order but with an image of cyclical patterning of multiple relationships with the center functioning as an interweaving of the various elements. This is in contrast to classic Western paradigms of literature and drama that normally contain a beginning, middle, and end with rising action, climax, and falling action. Blaeser quotes Lakota author Vine Deloria Jr., who states that the sequences relate to the integrity of the circle. She also quotes Laguna tribal scholar, Lee Francis, who says that stories are like a poem with emphasis on the middle of the story and the purpose, which is about the intersections in the relationships and which is offered to a wider audience. Furthermore, the “spatial, temporal, and spiritual realities of

Native people reflect a fluidity that disallows complete segregation between experiences of life and death, physical and spiritual, past and present, human and non-human (Blaeser, 1997, p. 11).

In my research, the stories that were developed into plays overlap with the real stories of development as they are part of a webbed circle that involves a return to the data, reconnection to the plays, and relationships of those who created the stories and watched the play. In this way I am analyzing the research through a cultural lens.

As a Fourth World Indigenous scholar, my goal was to create a sacred space where a discussion on STI/HIV prevention from both Indigenous and Western perspectives could occur among the co-researchers while focusing on both the conclusions of the inquiry and the connections in-between. This thesis moves towards that by answering the research questions in the subsequent chapters.

The Indigenous Iterative Webbed Circle

This section illustrates the use of an Indigenous Iterative Webbed Circle to demonstrate how a popular theatre framework and action research spiral can be merged and based on Indigenous values and teachings. I use the holistic model released by the Ontario government in 1994 as part of the Aboriginal Health Policy (Aboriginal Healing and Wellness Strategy, n.d.) and overlay it with concepts of popular theatre and action research. Furthermore, I use a dream catcher to link the concepts to the intricacies of narratives. The dream catcher is an appropriate metaphor, with the idea of Grandmother Spider centrally configured, as a spiritual entity, linking all parts to the whole.

The Indigenous Iterative Webbed Circle encourages researchers and co-researchers to work within an ethical space from design to analysis and beyond. By encouraging an understanding of Natural Law, abiding by principles of Community-Based Participatory Research and/or popular theatre, the researcher and co-researchers will understand health issues through a self-reflective and experiential process. Through the application of the Indigenous Iterative Webbed Circle, knowledge transfer and exchange encourages a humanist approach to research in First Nations[32] and Métis communities.

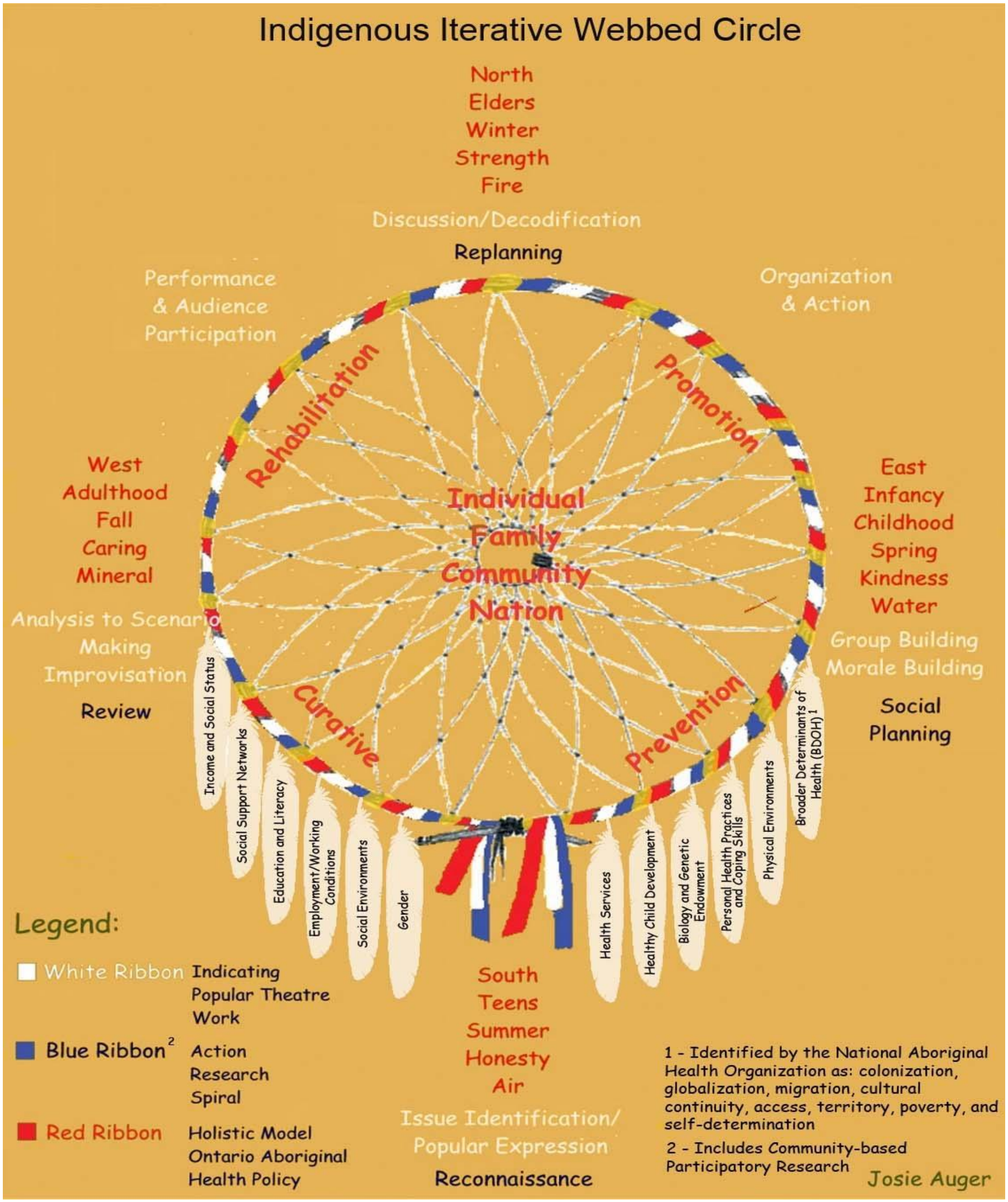

Figure 1. Applying popular theatre and action research concepts within the Indigenous Iterative Webbed Circle.

There are many types of wheels or circles representing the holistic. I chose this one because it is visual and weaves the mainstream health care concepts and Indigenous life cycles and natural rhythms. Ontario's Aboriginal Health Policy presents the concepts of the individual, family, community and nation.[33] The Circle framework weaves three interrelated concepts: the life cycle, holistic health, and continuum of care. The continuum of care addresses prevention, rehabilitation, curative, and health promotion. In the context of this research, I examined STI/HIV prevention and promoted holistic health focusing on the public health spectrum. While the Ontario Aboriginal Health Policy model can be applied to the fields of medicine focusing on rehabilitation and curative those interrelated concepts are beyond the scope of this research.

As a point of departure, my original research questions were framed to include the concept of the individual, family and community. As I began drawing the Medicine Wheel, I reflected on the values in each of the doors, east (kindness), south (honesty), west (caring), and north (strength), and I realized that those values are teachings that could be used to tell stories of what happened in the field while using popular theatre and action research.

The fit between the action research social planning and popular theatre's group building and morale building phase coincides with the eastern door on the Indigenous model. The eastern door contains the value of kindness and because the project started with social planning along with group/morale building, it required all of us to get to know one another through kindness. As the group was getting to know one another and the ideas around popular theatre and action research were introduced, our project was in the infancy stage of group and project development. An analogy for this is, a baby in a mother's womb is surrounded by water and we were giving birth to a project addressing STI/HIV prevention and we needed to be kind to one another.

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[33] I added nation as it has been applied in other models.

The value of honesty in the southern door coincides with the popular theatre concept of issue identification/popular expression and the action research concept of reconnaissance. Before we created scenes, we needed to understand the issue, so by taking action (reconnaissance) to understand STI/HIV prevention, we sought the truth by sharing knowledge with one another. The kernels of truth were fictionalized and developed into stories from the young people's perspective on sex, love, and relationships complicated by STI/HIV. This southern door reflects the summer season of one's life, the teen years, a time when we search for honesty in the world around us and to make sense of it.

Caring for the group and the individuals members is also an important cultural value. The western door offers a lesson for adults to show caring for the young and old in our society. The popular theatre framework moves us from analysis to scenario making/improvisation where ideas and issues are translated to stories about impact on people, and the action research spiral begs us to review our actions, and from an Indigenous perspective to do so with caring. It is the fall season, a time of maturity, a time to show others we care. Our group of young adults demonstrated care most of the time when we worked together but there was some strain with attendance problems rising as an issue. As we tried to develop scenes for the play the pressure was unnerving. However, during difficult times, such as when we got tested for STI/HIV and when the local media called attention to the HIV epidemic resulting in a local administrator fearing Chief and Council would ask us to leave, the group members showed they cared for one another by offering their homes as shelter in case the administrator's fears rang true. This worst case scenario failed to transpire and we successfully moved towards performance and audience participation. This is discussed in greater detail in Chapter Four.

Strength: the scope of the project required a tremendous amount of strength from each one of us. In the northern door, the winter season represents elders and the value of strength or resiliency acquired and maintained through one's lifetime. This representation coincides with the action research spiral of replanning and the popular theatre framework of discussion/decodification and moving towards organization and action. During the course of the project our group had support from the elders and we owe part of our strength to their support and the other part to our own resolve to see the project through.

After the performance was over there was still more action to be taken and although the group temporarily disbanded and the popular theatre practitioner concluded her part of the project, I continued to work on planning a gathering for STI/HIV awareness in the community that involved showing the play one more time. This action research approach to organization and action also required strength.

The idea of using colours comes from the use of ribbon as an offering.[34] Together pieces, of ribbon are tied around pieces of willow that provide structure to the frame separating the ideas of prevention, curative, rehabilitative, and promotion with the idea that individuals, families, communities, and the nation are impacted. The nature of the dialectical discourse is symbolic in the interweaving of each coloured ribbon around the willow. The Indigenous Iterative Webbed Circle is recursive, representing the ongoing cycle of Natural Law with respect to life patterns and natural rhythms among Indigenous individuals, families, communities and the nations who become involved in popular theatre/action research within a health care situation. Our existence as humans within this universe is based on Natural Law and it is on these laws that our culture is based.

The Indigenous teachings are depicted as a red ribbon, symbolizing the life blood of our peoples and to differentiate between it and action research and popular theatre. As stated in the Aboriginal Health Policy, the life cycle is seen as a passage of stages from infancy through childhood, youth, adulthood, into the senior years. Aboriginal holistic health embraces the life cycle and is represented in the four directions, using the four seasons and gifts of kindness, honesty, caring and strength, and the four elements of the environment: water, air, mineral, and fire. Moreover, the continuum of care, or healing continuum, incorporates health promotion, prevention, curative programs and services, and rehabilitation. The life cycle includes all members of the community at different phases in their lives. Each person has a gift to bring and a role to play in the community. In a healthy community each member is able to share his or her gifts and assumes responsibilities.

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[34] An offering is a gift to the spirit world.

The action research[35] is blue in the dream catcher. The colour blue signifies the healing that is required through talking about this sexual health issue and sometimes taking action to remedy the problem. Action research is about listening to one another and sharing stories about problems and in this way we help one another learn and heal. We also ask the spirit world to help us in our healing process as we discover the true nature of healthy sexuality. The action research spiral asks us to circle around and face the issue and take action towards STI/HIV awareness and prevention. This implies thinking critically about Indigenous sexuality and the effects of colonization.

Colonization has affected Aboriginal people's self-concept across generations. Left unhealed, the traumatic experiences of the residential school survivors is believed to manifest in multigenerational trauma resulting in their children experiencing sexual abuse and incest (Martens, Daily & Hodgson, 1988; Waldram, Herring & Young, 1995). Sexual abuse and incest are considered social problems. The psychological characteristics and behaviours of victims, offenders, and those who know about it, contribute to inappropriate sexual attitudes, knowledge, and behaviour within communities (Martens et al., 1988). The long-term repercussions of these inappropriate sexual experiences negatively impact individuals, the family, community, and nation. The oral tradition of deconstructing past behaviours is considered of primary importance to preventing future behaviours. As Sumara and Carson explain:

> Action research knowledge is not considered apart from the historically, politically, culturally, and socially effected conditions of its production. The knowledge that is produced through action research is always knowledge about one's self and one's relations to particular communities (1997, p. xviii).

It is a dialectic and iterative process designed to prompt reflection of one's self in the context of others in relation to a highly sensitive subject matter.

Limitations of time impacted the project and limited my ability to engage in repeated cycles. Originally, I planned to engage the co-researchers, elders, and popular theatre practitioner in a 16 week

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[35] The family of community-based participatory research includes action research. The principles of CBPR that include participation, cooperation in a joint process, co-learning, systems development and community capacity building, empowerment, and a balance of research and action fit with the action research orientation within this model that includes the action research spiral.

schedule of activities comprising three hour days, four days per week. Overall, each day was planned to include: updates on group progress that involved a talking circle on the process and topic; drama warm up exercises; a major drama based activity around the themes of the project; shared reflection and analysis; individual reflection and analysis; and closure exercises. Individual reflection and analysis was supposed to occur through journal writing and periodic one to one interviews at the beginning, middle and end of the project. Shared reflection and analysis was supposed to occur through talking circles. These methods would lead to a drama production.

Popular Theatre is woven into the Indigenous Iterative Webbed Circle and colour coded in white to depict change. White is representative of the change that results when stories are told and fictionalized, plays are developed and formed, and an audience reviews and discusses the topic.

As with action research, the process of popular theatre is non-linear. Popular theatre has been shaped by popular education and the life work of Paulo Freire (Boal, 1979; Freire, 1970). The dramaturgy of Berthold Brecht and Augusto Boal shaped the popular theatre process and expression (Cloutier, 1997). The ultimate goal of popular education and popular theatre is to emancipate the oppressed through the codification and decodification of pictures and stories, conscientization, dramaturgy, and emancipation processes (Boal, 1979; Cloutier, 1997; Freire, 1970).

The process of popular theatre includes morale building/group building, issue identification and popular expression, analysis, scenario making and improvisation (codification), more analysis, more scenario making and improvisation (Kidd, 1981: Prentki & Selman, 2000). These activities are followed by a performance and audience participation, and discussion (decodification), organization and action. The process can then circle back to issue identification and popular expression (Kidd, 1981; Prentki & Selman, 2000). Participatory democracy is an important philosophy and practice central to both action research and popular theatre.

This use of theatre requires collaboration and uses democratic processes to develop community action. A difference between popular theatre and action research is that popular theatre requires the group to use their bodies to act out and give voice to fabricated, fictional scenarios (that may be based upon real situations) often. This work is then put in front of an audience to heighten social consciousness. Popular theatre is considered “symbolic action,” and prompts interaction with an audience, whereas action research applies solutions to real problems in actuality (Berg, 1998). The power of enacting these stories theatrically is that characters and situations can be objectified as fiction and solutions can be tested and enacted to empower others who may experience similar situations in their lives. Strategies for change can be tested within the safety of play and fiction before being applied in real life. The marrying of action research and popular theatre is a union joined together by the popular theatre practitioner who works to maintain a dialectical discourse between oneself and the group members (Prentki & Selman, 2000). The process between the co-researchers, popular theatre practitioner and elders resulted in a production that was shared with the community members.

The yellow ribbon signifies the inclusion of community-based participatory research, synonymous with action research except that the action research spiral is reflexive and iterative.

Twelve feathers hang from the Indigenous Iterative Webbed Circle depicting the determinants of health. I exclude culture as a determinant of health for the sole reason that the health of Aboriginal peoples should be viewed through a cultural lens. In place of culture as defined by the public health agency of Canada, I replace it with the National Aboriginal Health Organization’s (NAHO) broader determinants of health in an Aboriginal context. Those determinants include colonization, globalization, migration, cultural continuity, access, territory, poverty and self-determination.

Principles of Methodology and Methods to Data Collection to Answer the Questions.

Speaking within the Indigenous Iterative Webbed Circle allowed me to frame my research questions and speak to the experience of living life at the edge, using the focal reality of popular theatre and the voices of the co-researchers to elucidate the experience of working with the popular theatre practitioner and elders to develop the play, “My Peoples’ Blood,” in an Indigenous community, their own and mine. STI/HIV affects not only the person, so I chose to use the Indigenous Iterative Webbed Circle in which the process begins with the individual then moves on to include the individual’s perception of how family and community view their involvement in the project.

This section describes the methods that were used to pursue prevention of STI/HIV in an Indigenous community. Posters and radio advertising as well as spreading the word informally helped me to recruit. The co-researchers/actors created a play and performed it for the community. The popular theatre practitioner is an instructor and experienced community-based theatre worker who was recruited through the Department of Drama at the University of Alberta. The co-researchers/actors received support from the elders as well as the popular theatre practitioner. Four community elders and three elders from outside the community were invited to provide teachings. Recruiting community members, elders, and a popular theatre practitioner was made possible through monies received from the Aboriginal Health Strategy - Alberta Health and Wellness.

Meetings with the co-researcher/actors occurred four evenings a week and sometimes on Sunday afternoons. The elders were invited to join us with the consent of the core group and popular theatre practitioner. A four-day week allowed the researcher time to transcribe tapes, administer the budget, plan day to day activities with the popular theatre practitioner while following the principles of action research, and prepare for the productions. The First Nations' education department rented a trailer for the group to rehearse in. Monies for the project were administered by the health department and I used it to support the local economy through purchasing food and supplies for rehearsals, cultural protocol, labour, and other theatrical items that were needed for the production.

The co-researchers explored issues surrounding and embedded in STI/HIV and safety. Through a popular theatre and action research process, they created a drama intended as a health education tool for their wider community. The elders were asked to share their stories and teachings on cultural issues. The popular theatre practitioner was contracted to co-facilitate the popular theatre/action research processes, which enabled the researcher to document the process and collect data and co-facilitate the process and discussion. The elders and the co-facilitator provided valuable support and historical context of the residential school on the intervention as it was developed. Finally, there was one evening gathering and performance presented to the community. The general community was the third group impacted by the intervention and those attending from the community provided information integral to this research.

The research questions were answered through qualitative analysis using the following data sets: participant journals, one to one interviews, talking circles and field notes. The one to one interviews were framed to elicit responses on the individual, family, and community levels. The journal writing and talking circles provided the co-researchers with an opportunity for individual and group reflection on the processes of action research and popular theatre. Field notes provide records of the major stages of this community-based project, and include observations by the popular theatre practitioner and myself, co-researcher's visual and theatrical explorations, the performance scripts created by the group, and records of the community performance events.

The purpose of using this methodology and methods to data collection was to answer these research questions:

1. Is popular theatre a culturally appropriate medium for introducing information to increase knowledge of STD/HIV in an Aboriginal audience?
2. Is popular theatre an effective way to encourage audience members to express their attitudes, knowledge, and behaviours related to sexual health?
3. How are popular theatre and action research methodologically and conceptually appropriate for preventing STD/HIV?
4. How do the influence of elders and a popular theatre practitioner affect the intervention?
5. Can the use of action research and popular theatre influence the attitudes, knowledge, and behaviours to promote healthy sexual choices?
6. Is narrative analysis a good way for Aboriginal people to tell their stories or have their stories told?

I obtained qualitative data from all three groups, addressing the research questions noted above. I used the data to: 1) write stories on the development of the play; and 2) analyze the themes contained in the play. In my analysis of the development of the play and the fictional story "My Peoples Blood," I observed how the two intertwined. I reported on these findings using the Indigenous Iterative Webbed Circle.

The youth's direct participation in this action research/popular theatre project enabled in depth consideration of all the questions, while the involvement of the elders and community helped to answer questions one, two, and five. The co-researchers were emotionally exhausted and focused on performing for their community and were not interested in compiling a summary narrative after this major event. As a result I compiled the results.

Chapter Four: Retracing Research Pathways and Processes

The relevancy of this chapter is explicit. Conducting research whereby a community is left with no tangible results or benefits has developed into “widespread distrust” of non-Aboriginal researchers in Indigenous communities (Brown, 2005, p. 80). This chapter demonstrates how to clear a research trail into the Sakaw[36] Cree territory of Northern Alberta, with respect for cultural processes and Indigenous ways of knowing. As the researcher, I discuss the importance of conducting research in one’s own community and based on this research experience, I share this knowledge. Writing about this research necessitates disengaging from a notion of being an unbiased researcher and letting the heart beat with life and purpose. This research touches the most intimate, life-giving part of who “we” are as Indian people while addressing STI/HIV prevention. This research was possible by working with a popular theatre practitioner, young people and elders. By encouraging the group members to voice stories of trauma created across generations, it affirmed my position that colonization has affected Indigenous sexuality.

This chapter explains the relative ease of access I had, as a First Nations person from the community, in obtaining approval and support for the project from the Chief and Council, Health Commission, and Alberta Health Strategy, which then led to obtaining ethical approval from the Health Research Ethics Board (B: Health Research) of the University of Alberta. Second, the meaning and purpose of offering protocol to elders to bless this work is highlighted. Third, processes of recruiting a popular theatre practitioner, core group members, and elders are traced. Fourth, this chapter provides a chronological description of the project’s community process.

Achieving community support was relatively straight forward. With partnership organizations like the University of Alberta and the Health Center, I obtained funding for this project from the Aboriginal Health Strategy Project Fund through Alberta Health and Wellness. After completing my PhD candidacy exam, I applied for ethics approval from the University of Alberta. With support letters from the Nation and the Health Commission, to accompany my proposal, I received ethics approval in 2005.

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[36] Sakaw is the Cree term for bush or woodlands.

Recruitment

This section of the chapter introduces the popular theatre practitioner and describes my travels from the plains to the bush. With the support of the popular theatre practitioner the recruiting process of the core group members was successful. The process of recruiting elders is described. A chronological description is presented by beginning with a turn to the eastern door of the Indigenous Iterative Webbed Circle.

I asked theatre artist Jane Heather to work on this popular theatre project in this Northern Alberta community since she was familiar with the community through her work there in the mid 80s when she facilitated a 3-year Native youth theatre project. Her familiarity with the community meant less time spent unravelling culture shock and on this count she was an asset to the project. In retrospect, having a popular theatre practitioner was a vital part of this research project. Through action research and popular theatre, Jane and I shared the role of Grandmother Spider,[37] a role with a responsibility to bring “thoughts or ideas into being” (Gunn Allen, 1991, p. 33). Jane Heather’s role was to facilitate the theatre development and rehearsal process for the group. I would support the effort of the popular theatre practitioner while attending to other aspects of the research project, including collecting data, managing the budget, involving elders, using the action research approach towards social activism and reporting those results as needed. Sometimes my role overlapped with hers. This is discussed later in this chapter. Our goal of working with the Indigenous youth to create a drama that addressed how a community’s sexual nature has been afflicted with life threatening diseases was accomplished in the course of this project.

Before the popular theatre practitioner arrived, I spent one week in my Northern Alberta community settling into a temporary home and beginning the process of recruiting core group members.

I left my comfort zone and as I write about that experience, I explain the research process and results “as something inextricably tied to the complex relations that form various layers of communities”

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[37] Grandmother Spider has been described by Paula Gunn Allen (1991) as a major deity whose medicine power is so vast that she brings thoughts or ideas into being and the similarity that I see, is that as a popular theatre practitioner and researcher we bring thoughts or ideas into being through popular theatre and action research.

(Sumara & Carson, 1997, xvii). As I moved with my daughter from Hobbema, I traversed from the southern plains to the northern forests of Alberta. As the images of the landscape changed, I reflected on the historic events that have had an impact on the people and the land. This discourse serves as a prelude to recruiting the core group members and elders into the research project and creating a play entitled, “My People’s Blood.” Historically, Aboriginal people have been subject to forced assimilation in the residential schools. The very nature of their sexuality changed from a natural state to experiences of abuse. Those experiences were shared as one generation informed another generation and a cycle of intergenerational trauma developed.

We arrived in the community on a spring evening. We admired the beauty of the sky, land and the lakes. I “tried” to maintain this state of awe even as I observed truck after truck hauling loads of timber and other resources from the area. Despite the industry almost ruining this moment for me, being in Northern Alberta was a breath of fresh air! It is not that living in the plains was without reminders of industrialization; to me the prairies are also a reminder of what Indigenous peoples have lost. The railway and trains that pass through Hobbema on a daily basis remind us of the fact that the people have lost a free lifestyle of hunting buffalo. It is a tragic loss.

Our grandfather,[38] the buffalo, is absent from the prairies and we grieve that loss. Instead of seeing buffalo roaming freely on the land, we see the reserve land being leased out to non-Indigenous farmers. Reserve lands are far from being part of nature’s wonder. There are few places on this Earth that have not been ruined, and that people can enjoy.

The discontent brewed slowly and over the course of the long drive my mind wandered to other places and moments in time.

Despite these feelings of discontent, I was appreciating a majestic moment with my daughter in Northern Alberta. The land was full and rich with trees, animals, lakes, and fresh air. There was plenty to

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[38] The term “grandfathers,” is used to describe the spiritual entities that exist on different levels. Humans are spiritual beings on an earth walk and we are making a connection to the different spiritual entities that exist on the different levels.

nurture my soul and it helped me to ground myself for the difficult task of recruiting young people and elders. The young people between the ages of 18 and 25 would form the core group, while the elders would form a supportive second group. Since this research was exploratory in design, I did not know if the young people would be interested in popular theatre and action research and STI/HIV prevention or whether the elders would respond to topics about sexual health.

My research did not fulfill the action research[39] requirements of involving the group in the social planning phase. Social planning had begun before I arrived in the community. It happened when I first wrote the proposal for acceptance by the Faculty of Medicine and Dentistry. It was not a community-driven approach but an approach driven by a community member. All it takes is one person to make a ripple effect. Despite not having other community members by my side to help write the proposal, I continued developing the proposal by believing in my dreams, of people wanting to do this work, and believing in the power of the elders' prayers. As I stood on the highway with my daughter, I knew that to manifest the prayers, it would require a tremendous amount of time and energy by me, my partners, and the people.

The Health Commission was very supportive of this project and they let me, my daughter, and the popular theatre practitioner live in one of their triplex units.

My daughter and I explored our new temporary home. Some community members referred to these triplexes as 'the mansions' because good housing is difficult to find and these places have two bedrooms and are furnished with five appliances.

Alone with my daughter in our home, I began to unpack my car. As I walked across the manicured lawn and looked around at the other cardboard cut-out units around me, I wondered what this research project would be like. As I unloaded bags of clothes, boxes of books, and household supplies, I was beginning to wonder what it would be like to live with the popular theatre practitioner. Over the next two weeks as we settled in, it turned out that we would carve out a decent partnership.

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[39] Minkler & Wallerstein (2003) state that CBPR requires equal participation in a joint process where everyone participates equally.

At home that night, I met my neighbour. She told me that some health center staff did not want their community presented negatively. She was making reference to an HIV report that a community member, had written and was waiting to release (Auger, D., 2005). If some community members had those concerns about information presented in her report, I wondered what they would say about my work. My fellow community member had worked hard to put that report together and if the community members had concerns, I did too.

I cautiously went about the community asking permission to put my plain posters on the already crowded poster boards throughout town. These were the posters I had quickly prepared for ethics review. They were not appealing to the eye, nor did they resonate a feeling of kindness and compassion, but, the information was there, if unnoticed. Unfortunately, I did not get one call. Then I thought maybe the best way to inform people was through word of mouth. I spoke to numerous people in the community and managed to get a lead to three people who would become members of the core group. Meanwhile, I sent an email to Jan Selman, my co-supervisor, wondering if it was allowed to put an ad on the radio since announcing the project on the radio was not included in my proposal. I received permission from my co-supervisor. My responsibility was to learn how the community works and adjust processes while holding to the spirit of the ethics principles.

The popular theatre practitioner arrived and we toured the rehearsal space at the “Old School,” a cluster of brown trailers used in previous years as classrooms for elementary students. A community member informed us about a drama performance on developing safer communities which was going to be presented in the community that week. She directed us to the drama teacher at the high school for names of former students to contact. Meanwhile my daughter, Chloe, decided to follow Jane’s idea and colour some posters using felt markers. Coloured posters were effective and attracted attention. Chloe added the bottom line “p.s. Help your fellow human being!” This important last line resonated kindness and compassion. One person mentioned that she saw the posters and liked the line. In retrospect, it connects to the concept of kindness found in the Indigenous Iterative Webbed Circle, which is also associated with the popular theatre framework of building morale, while developing a group. It was also part of the social planning phase of action research that involves extending an invitation. Some other examples are provided below.

The popular theatre practitioner and I went to see the drama teacher at the local high school. He gave us a list of people who he thought might be interested. Meanwhile, I contacted CFWE, the Aboriginal radio station, and put the ad on the air while Jane began calling people. I joined her at the Health Commission office where we had a cubicle to work from. Momentum was building.

We went to the Safe and Caring Workshops[40] at the Community Hall. They gave us permission to announce our meeting. While at the event, a couple of people mentioned that they had heard the ad on the radio. People were expressing interest and talking about STI/HIV prevention.

On May 4, 2005, we had our first community meeting. At this meeting, it was important for me to determine their ages as the intent of my project was to reach 18 to 25 year olds. The rationale for recruiting young adult youth was that many are sexually active and more likely to be single. I was also developing a schedule to accommodate the needs of the group. The following people[41] came to find out about the project. Some of them became members of the core group.

1. Doug was a 24 year old man who worked during the day. Doug became a member of the core group.
2. Rocky was an 18 year old man who worked during the day. Rocky also became a member of the core group.
3. Leon was a 21 year old man. He attended that first day but did not come back.
4. Willow was a 23 year old woman who worked during the day. She became a member of the core group.

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[40] The Safe and Caring Workshops occurred monthly. They were developed as part of a 3 year project that ended in March 2006. The purpose was to cover five topics: 1. Living respectfully, 2. Self-esteem, 3. Respect and diversity and prejudice, 4. Managing anger and dealing with bullying, 5. Working it out together – conflict resolutions.

[41] Throughout this thesis, names of participants are changed, to preserve privacy and anonymity.

5. Jasmine was a 20 year old female who also worked during the day and became a member of the core group.
6. Leila was a 19 year old female who went to school during the day and became a member of the core group.
7. Tatiana was a 17 year old girl who wanted to become a member of the group but because of her age and my ethics requirement, I had to refuse her.
8. Karen was a 22 year old woman who became a member of the core group for the first few days. She let me interview her but then she dropped out.
9. Cassandra was a 20 year old friend of Karen's who also became a member of the core group. She let me interview her but then dropped out after a few days.
10. A community leader came for the first day because she was interested in the project and offered her support at the community performance.

I explained the project to everyone who came and what would be required of them. I informed them that this project was funded through the Aboriginal Health Strategy – through Alberta Health and Wellness. I informed them that since they were offering their time and energy to this project, I was offering them a monetary gift. Of these nine people who came to our first meeting, five became members of the core group. The community leader was not included in the count. Of these five original members, three stayed with the project. In retrospect, this project would not have happened without the financial support of Alberta Health and Wellness because the time and energy that it took to do this work combined with the sensitivity of this topic, might have caused more people to drop out without motivation to stay. A community member informed me that, in this community, some agencies host events and sometimes only one or two people attend, so we were very fortunate to get the participants that we did. Jane and I stepped forward into the circle to start the project.

After I explained the project, the popular theatre practitioner introduced the "Warrior Stick," exercise which helps to develop groups and their morale. While gathered around the circle, we each had the opportunity to hold the warrior stick, say our name, and identify something that we believe in or stand for. As we spoke our truths, I heard the people who attended the first day identify who they were warriors for. It was a moment of truth for each of us, as we stood in front of one another identifying something we believe in enough, to stand up for. Rocky said that he was a warrior for the people and he lived in the "back roads" of the community. A community leader who showed up identified that she was a warrior for the nation. Others stated that they were warriors for themselves or for their friends and families.

For me, holding the warrior stick was a moment of poignancy. My heart beat faster. There was no place to hide. I felt shy and nervous standing in the circle as I said that I was a warrior for STI/HIV prevention! As awkward as that was, I was that warrior. I was there to see if the project would work and to see if it would make a difference. That was my truth. Holding the warrior stick and speaking my truth was a serious reminder for me to balance the cultural values of kindness, honesty, caring, and strength along with humility because it is important to be a health warrior, more specifically, a health warrior with a heart. The warrior stick exercise helped us identify our mission in that particular time and space. In so doing it was important to create an environment that was safe. We all participated in the activity and we treated one another with respect. This helped to build a safe environment to create stories on STI/HIV prevention.

Later on, I recruited Diane and Nicki because we needed more people to participate and be supportive. They stepped into their roles with ease and the group seemed comfortable with their involvement. I asked Diane, an older female, to become involved because she was interested in the health topic and I asked Nicki to become involved because, in her professional role as a mental health therapist within the community, she would be able to help anyone within the group if they needed someone to talk to.

Two weeks before the production, Doug and Leila, two members of our core group, dropped out. The group was disappointed but wanted desperately to perform so we decided to recruit three friends and/or family members so that the play the original group had created could go forward. Rae Anne and Byron joined and I allowed my daughter to take a role. The group followed the golden rule of theatre that the "show must go on!"

As a researcher, I believed that elders could provide support to the young people who were engaged in this STI/HIV prevention project. Initially, when I began framing my research proposals I included elders Frank Daniels and Isabel Auger to help support the research process because they already had attachments to the community and since I had worked with them before I knew they would provide support and be able to teach culture. I also wanted to include elders living within the community. This required obtaining names from the core group members of elders they wanted to support them during the course of this project. After the first initial visit with Isabel and Frank during the first week, I asked them to think of elders they wanted involved in the project. I recall Jasmine looking at her peers with some confusion because she had not worked with elders. By the third week I prompted them again and they gave me some names.

I recruited elders from the community based on suggestions from the group members, a community member, and Isabel Auger. Recruiting elders to form the second group that supports the first group was a process of kindness. It involved visiting and offering them cultural protocol and/or asking them to be involved after having explained this project to them. The four elders[42] included Mark, Deidre, Helen, and Bernard.

Feeling satisfied that the elders group had a balance of both men and women who were Métis and First Nations, I stopped recruiting. When I first visited them at their homes I gave them tobacco and invited them to attend our project and provide support to the young people. Each time the elders attended I provided an honorarium of two hundred dollars.

Not all the elders smoked tobacco nor were they all practitioners of Native spirituality but they respectfully accepted the tobacco. Generations of Indigenous people within this community have been indoctrinated into one of the main religions in the area, Roman Catholic, Anglican, or Pentecostal, or they do not follow any formal religion. There are some who still practice their Native spirituality. I did not ask if their religion would prevent them from participating in this project even though it is known that the

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[42] Their names were also changed to preserve privacy and anonymity.

Roman Catholic clergy and congregation have differing views on prevention issues, “such as condoms and needle exchange” (Medical News Today, retrieved August 25, 2006). By accepting the pouch of tobacco, they accepted the role as supportive elder within the group, in the prevention of STI/HIV. To me, this was extremely significant because in a small way they were brushing aside “old school mentality” for an important purpose. In this context, the attitude that I refer to is an acceptance that Native culture and spiritual practices are bad or evil. By accepting the tobacco, they were accepting the Cree cultural practice of providing tobacco to elders. Elders are revered in our culture. They are a link to the past and so much of the past was undermined by Church and state. I viewed their acceptance of the tobacco as a decolonizing gesture.

Before I had all of the elders together visiting the core group, we were in the eastern door of the Indigenous Iterative Webbed Circle that included the popular theatre aspect of group building/morale building and the action research aspect of social planning. The project was in the infancy/childhood stage and we treated one another with kindness.

Chronological Description

Using the teachings of kindness offered in the Indigenous Iterative Webbed Circle, we began. The popular theatre practitioner facilitated a number of games to help group members make their bodies expressive, without using their voices. There was a laughter and enjoyment in being silly and creative. During this infancy/childhood stage the popular theatre practitioner took a step towards issue identification. Using kindness helped to develop trust. From the playful to the serious, we began to identify STI/HIV in the community. The popular theatre practitioner brought in a black cloak and mask for each group member. They were asked to don the cloak and mask, and position it in relation to where STI/HIV is positioned in their lives, to metaphorically signify HIV within our families and community. The exercise brought the reality of this deadly disease into closer proximity. We were getting to know one another and starting to build a “circle of trust,” as described by one core group member. We still had not invited the elders in as part of the process. At the same time, there were significant events happening within the community and the news of the residential school demolition was making the local headlines.

Decolonization was occurring in the spring/summer of 2005. It was evident in the stories that the local newspaper was publishing on the demolition of the residential school and stories from survivors. The residential schools in Canada are a manifestation of the assimilation policies of the colonial government (Ray, 1996, pp. 235-243). While "the last one closed its doors in 1988" many of these structures remain standing and they are a reminder of the sometimes unspoken pain and dysfunction that has resulted among individuals, families, and communities (Ray, 1996, p. 242). My community was demolishing a Roman Catholic residential school during the spring and summer of 2005. Some people considered the demolition as an attempt to heal the memories "for past abuse" (Fever, June 30, 2005, pp. 3-6). A community member who survived the residential school was concerned about the intergenerational impact of the social problems stemming from the residential schools and recognized that healing is important (Fever, June 30, 2005, pp. 3-6). These events were happening and being reported in the local newsletter.

These external events were part of the sub-text of layers contributing to story development and group sharing. It helped the core group members understand how one's identity is shaped by the experiences of older generations. It gave the elders an opportunity to discuss their experiences. This discourse bridged the past to the present and the impact on identity.

Elders Frank and Isabel came to the community on May 10, 2005. The purpose was to introduce them to the group and explain their supportive roles to the project. The group had to familiarize themselves with the idea of working with elders because they were not used to the concept. During this first meeting, Frank agreed to present some traditional teachings to the group on May 18, 2005. It was a day that the popular theatre facilitator would not be able to attend so I planned to fill the time by inviting the elders to participate and share. Even though the entire group was not there, information was shared from a public health and Indigenous perspective. Elders Helen, Deidre, and Bernard, along with our core group members, Willow, Jasmine, Doug, Leila, and Nicki listened to Elder Frank Daniels and Nurse

Shelly Gladue. The group had the opportunity to learn about the transmission of the virus and how to test for HIV, and about the holistic concepts of health through the teachings of the sweetgrass and medicine wheel. Those who were not there missed out on these teachings and those that attended were ready to listen and understand the teachings. As Ermine postulates, creating sacred space is "for human advancement" (Ermine, 2005, p. 4). I add that it is a process whereby Native people can begin to understand Indigenous and Western approaches to disease prevention, specifically STI/HIV. This is an example of knowledge translation and exchange as defined and explained in Chapter Seven.

A nurse from the Health Commission and member of the Ribbon of Hope Society provided a clinical perspective on HIV transmission and testing. Her presentation was important for two reasons. One, so that the elders and co-researchers could understand the virus has no cure. Second, so that they could understand the importance of HIV prevention and testing.

In an Indigenous community that has experienced cultural loss across generations due to the colonization process, I worried that some of the group members might have internalized the oppressive colonial stigma that "culture is evil" and that those who practice Native spirituality are pagans and heathens. I worried that they would reject the traditional teachings of elder Frank Daniels. The dehumanizing colonizing process was not as effective as I originally thought. After the nurse's presentation, the elder presented the meaning of sweetgrass and prayed for the group before beginning his talk on the Medicine Wheel. Doug helped Frank Daniels by lighting the sweetgrass and carrying it around the circle for everyone to smudge[43] before the elder began the prayer. One of our young women could not participate in the smudge and prayer because she was on her Moontime[44]. After cleansing with the sweetgrass, the core group members and supporting elders were ready to listen to Frank's Cree cultural

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[43] To smudge refers to purification of the mind, body, spirit, and emotions by holding the smoke and bringing it oneself.

[44] Moontime refers to the monthly cleansing cycle in which it is considered that women are in a powerful time and do not need to purify themselves with Sweetgrass because their body is already cleansing itself.

perspective on disease prevention. By living according to the teachings of the medicine wheel[45] and using sweetgrass, STI/HIV prevention is possible.

Co-researchers were introduced to these ideas: Living according to one's cultural standards and values is about living one's life to achieve balance and harmony in all aspects of mind, body, spirit and emotions. Some aspects of traditional lifestyle have changed. Long ago some tribes were polygamous to increase the gene pool, increase the odds of survival and follow customs, however, in this contemporary era monogamy or abstinence has become the norm to avoid the spread of STI/HIV. By following contemporary social roles with traditional values and praying with sweetgrass, one's faith lies in the belief that the spirits can help the humans. There is no boundary between the spiritual world and human one. A spirit can help a human but a human has to help herself through consistent abstinence, condom use, or monogamy. Unprotected sex within one relationship after another is not good enough.

Generally, the young people in my community do not know their traditional teachings and their families have stopped practicing their culture. Like Taiaike Alfred who recognizes that young people are experiencing "anomie," I recognized this in my own community (Alfred, 2005). From my generation to this younger generation, I could see that not having cultural standards and values caused instability. Any doubt or hesitation that I had about imposing my beliefs and restoring cultural identity among the youth of my community were quashed when Bernard expressed his support and wish to befriend Frank for the good teachings. There was consensus from elders Deidre and Helen. When co-researcher Leila asked me if we could have a sweatlodge ceremony, I knew that Frank's teachings had left an impact.

We set a date to have a sweat which Frank and Isabel would come back to the community to conduct on May 26th, 2005. This decision was made without Jane and it had ramifications later. In the meantime, inviting the elders to our group introduced the young people to their cultural role models, thereby reintroducing their values and beliefs and cultural ideals to establish some stability and avoid that feeling of alienation and loss that so many young Indigenous people experience.

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[45] The Medicine Wheel teachings that Frank Daniels introduced were not recorded for cultural consideration.

According to Natural Law[46], the elder's role is one of passing on traditional knowledge to the people through the oral tradition. In this way, and through lived practice, young people acquire the teachings so they can conceptualize beginning to live according to the values of Natural Law. Chino & DeBruyn (2006) identified the role of elders as "promoting commitment" and elders become advocates and mentors to younger, interested people (Chino & DeBruyn, 2006, p. 597).

Living a culturally-based life is miyopimatisiwin[47]. The majority of people within my community have been disconnected from their birth right because of the impact of foreign substances and historical trauma. One of the teachings I received when I was a young adult was that we are supposed to leave alcohol and drugs behind us when we walk the sweetgrass road. It can be a difficult challenge when so many other young people are using. Sometimes it takes hitting "rock bottom" before people are ready to give up alcohol and drugs. For some addiction and unresolved trauma leads to prison before the decision to change can be made. James Waldram (1997) refers to the work of elders in prisons as addressing the affects of colonialism and oppression linked to post-traumatic stress disorder [PTSD] (p. 43). Individuals suffering from this disorder experienced traumatic life events such as natural disasters, personal violence, prolonged or acute trauma, terrorism or kidnapping, even childhood sexual abuse and extensive family violence (pp. 43-44). Waldram (1997) states that, "programs of assimilation" such as the residential schools, community relocation, and terror brought on by widespread substance abuse are linked to cultural oppression of Aboriginal spirituality (pp. 46-47). Maria Yellow Horse Brave Hart (2004) identifies historical trauma [HT] as "cumulative emotional and psychological wounding, over the lifespan and across generations, emanating from massive group trauma experiences" (p. 7). HT goes beyond PTSD as PTSD is "inadequate in capturing the influence and attributes of Native trauma" (Yellow Horse Brave Hart, 2004, p. 7). Not only through the direct experience of programs of assimilation but through

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[46] Natural Law is a belief system that Aboriginal people use to help govern themselves, families and communities in accordance with Nature.

[47] A Cree term for living a good life.

intergenerational trauma across generations that people are caused to "self-medicate to reduce the emotional pain" (Yellow Horse Brave Hart, 2004, p. 13).

In prisons, inmates have opportunity to learn about Aboriginal culture, but the culture needs to be taught at younger ages to prevent what Alfred identifies as anomie. Waldram addresses the importance of learning the culture, "[i]nsofar as individuals come to understand these values and behaviours, the symbols and their meanings, they may begin to change their own behaviours and attitudes" (1997, p. 98). Maria Yellow Horse Brave Hart (2004) states that "[b]oth prevention and treatment need to focus on ameliorating the HTR and fostering a reattachment to traditional Native values, which may serve as protective factors to limit or prevent both substance abuse and further transmission of trauma across generations" (p. 14). At the time of this project, the core group members were not alcohol and drug free but at least they had the opportunity to acquire some of this knowledge and appreciate their Native culture through the strength and wisdom of the elders. The role of alcohol and drugs in the transmission of sexually transmitted infections was a focus in the play the group created.

According to Willow's journal[48] for May 18th she wrote:

> *I believe that our group will get stronger as our trust and comfort grows. The sweatlodge idea is a great way for all of us to connect spiritually, mentally, emotionally, and physically. I want to do better and contribute as much as I can to this project. I want to be able to share my stories and experiences with the group. I know once the trust is there that we will all be able to spread our wings, open our hearts, expand our minds, and really get going full speed ahead as the weeks go by. I won't give up on this and I won't give up on you Josie. I want to help and be here for the group, for you, for my community, my elders, and for myself. I think we need to have some sort of event or something to bring awareness to the community about what we are doing here. We could have a walk or something to let people know that we are doing this. Maybe we could get some more support from people. Today was a good day. Shelly's [the nurse's] presentation was informative and Frank's talk was interesting.*

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[48] The use of quotes from journals are included,

> *I do want to get more in touch with my spirituality and I hope the sweatlodge idea will set my foot in the door to a new journey or beginning. I look forward to Sunday. – Willow*

Willow's comment reflects the desire for a holistic connection between the elders and core group members to continue developing a circle of trust and momentum towards community awareness through a walk. Later this idea develops into participation in the Canada Day parade. This is discussed later.

According to her journal for that same day, Leila really enjoyed the evening with elders. She was very enthusiastic about experiencing a sweatlodge ceremony. She writes about her experiences of oppression from other girls and how she used alcohol and drugs to cover up her pain. Leila recognized that having a spiritual connection is important to avoid dysfunctional patterns:

> *Oh my gosh! Today was so nice… I absolutely love listening to elders. My grandparents used to tell me their stories of the good old days. They made me wish I could have grown up in the fifties or, whatever decade was the best. I realized by listening to Frank that I need to get more in tune with my culture, I do believe that turning to the Creator is a healthier way than drinking my problems away. Since the age of 16 I turned to alcohol to give me my strength, to face the day. I would drink a mix of Malibu before going to school, why? I was threatened and harassed so badly, I just wanted to escape. Girls would say to me, "you're such a skank, I'm gonna kick your ass tomorrow!" I would get so terrified, I thought if I drank a little bit I wouldn't feel a punch. This became an everyday thing. These girls were calling me a skank, slut, whore, etc. But in reality I wasn't sleeping around, it wasn't until after, I started being promiscuous. I lost all respect for myself, and my body. I thought nobody else cares about me, so why should I? I hated living, I hated everyone. I just wanted to die. I started doing drugs, such as crystal meth, and cocaine. I thought maybe I could "accidentally" overdose, and my pain would be gone. Thank God it didn't work. I got help from my mom, my grandparents, and my sisters, almost everyone in my family. I love so many of them with all my heart. I am now building myself up, so they can be proud of me. – Leila*

Leila's beauty as a young woman caused a jealous and violent reaction. In my opinion the victimization she experienced is a symptom of the dysfunction in the community. Had she learned about, the culture at an earlier age, she might have learned to value her role as an Indigenous woman and protect herself. Learning about cultural roles would help her and others avoid the social regulation of promiscuous behaviour through lateral violence. Our Indigenous culture offers teachings on the roles of women by women. If the community offered these teachings to community members, then the values of Cree sexuality could be relearned. In my opinion, having Frank Daniels share some traditional knowledge with this group was beneficial. It was clear that Leila was eager and willing to learn more about it.

One day Leila's mother stopped in and thanked me because she was very glad that her daughter was involved in this research project but she was also concerned. Although Leila brought to my attention her bipolar disorder which caused her moods to swing high and low, I was not alarmed by her condition. She had heightened feelings about being involved in the group because there were blended family issues, explained her mother. Willow and Leila were sisters through marriage. Leila's step-dad was Willow's father and Willow had some resentment towards her father. Leila's mother felt Willow's resentment was being directed towards Leila who was younger and less influential within the group. I made a decision not to bring it up within the group and neither did Willow or Leila. This underlying current of discontent and not talking about their blended family dynamics might have had a bigger effect than what was expressed. Weeks later Leila expressed disinterest in attending. It was not clear if Leila's family dynamics caused her to drop out or if there were other reasons involved. For ethical reasons, I did not question her reason for leaving. Leila wanted the sweatlodge ceremony but she did not attend.

The Indigenous Cree epistemology came into praxis when most of our young core group members put their values into practice by participating in the sweatlodge ceremony. "Praxis is thoughtful reflection and action that occur in synchrony," and is about movement towards "transforming the world" (Chinn, 1995, p. 2). When theory meets practice, it is praxis. It is when "knowing" and "doing" are the same (Chinn, 1995, p. 2). Co-researchers had the opportunity to apply the "knowing" into the "doing" for their personal growth.

Not everyone was able to attend the sweatlodge but those that listened to the elders had cultural knowledge translated and exchanged to them on the Cree cultural perspective of disease prevention. One female group member had doubts about attending the ceremony and she wanted to be sure about her decision, so before coming over, Willow spoke to her kokum[49]. She told us that her kokum advised her to go and check it out and if she felt right about it, then she could participate. Willow's kokum then gave her something to wear. When Willow told me this story, I was somewhat surprised that she was having doubts but relieved that her kokum supported her granddaughter's judgement. Once again, the family members were demonstrating support of the youth who were involved in this project and their support had a positive impact.

Before the sweatlodge, I had to leave the group due to a family emergency. While I was away, Jane worked with the core group but they were disinterested. Instead of doing drama, they went to a round dance commemorating the demolition of the residential school. The popular theatre practitioner noted[50]:

> *Josie's absence is a dark star force, unseen but felt. Nothing worked. Everyone was out of step. I could not get anything to cook, to move. We did some work on the male story but pretty soon everyone was leaving the room. It was kind of awful. I said what I always say "please make every effort to be on time," and the defences went up. Instantly everyone had an excuse. It was ugly. Around 8:30 pm Rocky said he had been at a community event to mark the demolition of the residential school. We decided to go. So they all ran off, I cleaned up the room and went too. The speeches were over but the singing, drumming and round dance was still on. We sat at a table and Rocky even challenged me to dance, I said if I do, we all do. Nicki, Jasmine and Leila were all on their moon time so Doug, Rocky, Willow and I danced. OK, so a positive thing happened.*

Ceremonies like round dances tend to make people feel good because they see the beautiful spiritual part of themselves expressed in the dancing of others. As I analyze this significant event based on the data provided by the popular theatre practitioner and co-researchers, it would seem that community members would normally be feeling positive to attend a round dance but I think after having witnessed the

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[49] In Cree: grandmother.

[50] Based on the field notes of the popular theatre practitioner.

demolition of the residential school, round dancing might have felt a little contrived at a time when people were thinking about how their families were negatively impacted by the residential schools.

The next day, Jane seemed less than satisfied with the group and her role in it. She explains the significance of this:

> *The session was better last night...Everyone arrived late as usual so we didn't get going until 7:00 [pm]. I get to the space at 5:00 pm or before and prepare and wait. I have been putting a clear plan on flip chart paper for everyone to see but I just scribbled last night. I felt they needed to say what they wanted to do. And they did. No drama, just drawing and memory box. This is very significant. I of course went with what they said. Willow led the warm up. We played a game and then drew. We got the male friends and family stuff done. Then they worked on their memory boxes.*

Allowing the group to decide what they wanted to do was significant. Their choice to do crafts instead of theatre was odd because they were working with a professional popular theatre practitioner. In my opinion, even though the group members said they missed me I think it was not that so much as a need to process the demolition of the residential school.

In my opinion, when something significant happens in a community, as in this case, not expressing the effects of internalized colonialism would have been stifling to their emotions and spirit. Like other community members, the group had watched the demolition of the Roman Catholic residential school. Knowing that the structure was operated by the Church and financially supported by the government with the intent to commit genocide on Indigenous children, who happened to be their parents and grandparents, the impact of the demolition would have been significant. Generations of Indigenous children were abused by the priests and nuns. There was historical trauma across generations. Although I was not there, I could imagine what people must have felt, as evidence of this haunted and colonial relic was destroyed before their eyes. As the round dance started they were left to hold hands in a dance and to find comfort in one another's eyes as they attempted to let go of the past and reconstruct the present. Rather than talk about the demolition of the residential school, they focused on my absence and described those two days as a time when they experienced an imbalance. Perhaps the imbalance they were feeling was related more to the after effects of the demolition, than my absence.

After looking beyond the rehearsal walls to the demolition of the colonial artefact, the group members wrote in their journals about the round dance and working on their other projects and working with Jane. They did not discuss the effect of watching the residential school be torn down. By following the group's decision to attend the demolition, Jane and the group members were witnessing a moment in the community's decolonization process. Although the popular theatre practitioner was questioning her purpose and role there, it had nothing to do with her personally. It was the need to discuss decolonization in an Indigenous community.

Jane had spent over three weeks in the community and she was reaching a turning point. She had asked them why they did not want to engage in any drama activities and they told her it was because I was not there. She wanted them to think more critically about this. She compared the difficulty of drawing and painting, with the conclusion that drama is harder than drawing. In her journal, Jane wrote:

> *I wonder if it's just too [difficult]? I don't want to give up on this process but in terms of sharing the power they have to commit, they have to be there, they have to stay there and they have to do the work. We'll see.*

I agreed with Jane that the group needed to commit themselves to their work as co-researcher/actors because their role was crucial to the success of the project. Perhaps if I had been there I could have directed the conversation towards the effect of watching the demolition to see if that was why they did not want to do drama. I think it was the reason. Perhaps working alone and quietly on their memory boxes allowed them to process what they were feeling.

When I returned, Rocky made an analogy that my absence was like an unbalanced tripod and because the tripod lost one of its legs the tripod fell. He even went on to say that I was the life and Jane was the force. It was a wonderful metaphor about balance and I would add that it was not only my absence, nor Jane's absence, nor the group members' absence – when attendance fell short, it caused us to lose power as a group. As a group, we needed to share, create, and enact stories.

It took two of us to be Grandmother Spider in this project with this group of young people. In that moment Jane could not weave magic and create stories with the group by herself. I could relate to the self-reflective questioning that she went through. I had done the same thing the week before she arrived, waiting for phone calls after I put up the typed posters on a crowded poster board. Like the posters I created, I faded into a crowded space. When Jane arrived and when she came to recruit, I felt her strength. In my opinion, when you are out of your comfort zone and working on sensitive issues with people you hardly know, the self-reflection process can cause you to question your role and the contributions you can make for social/health change. It helps to have someone to work with in synchrony.

On May 30th, we invited the elders to participate; Helen, Bernard, and Mark joined our group. Elder Mark began with a prayer. I took the lead and encouraged the elders to speak.

I conducted a presentation of Omram's (1971) epidemiological transition theory as it applies to Canada, not to discuss age threshold limits or make claims for public health and modern medicine but to introduce the idea of infectious disease decimating populations in the 1900s with a decline and a rise in injuries, diabetes, coronary heart disease and cancer (Young, 1994). I explained that infectious diseases are once again on the rise, HIV/AIDS claiming a proportion of those numbers, globally. The core group and elders nodded in agreement with the information, as we can all relate to losing loved ones to influenza epidemics, tuberculosis, motor vehicle collisions and other injuries, and to dealing with the morbidity of diabetes.

Then I read a letter written by William Blackwater (1998), from a report entitled, ``The Red Road: Pathways to Wholeness an Aboriginal Strategy for HIV and AIDS in BC.`` In 1965, Blackwater, who would have been approximately in his late thirties when he wrote the letter, was taken by Indian Affairs to the Alberni Indian Residential School, 1000 miles from his home. He states that through the Healing Foundation consultations, "HIV/AIDS history has a very 'minimal connection' to the legacy of various Indian Residential Schools throughout Canada" (BC Aboriginal HIV/AIDS Task Force, 1998, p. 17). Then he pointed out how he was sexually abused by his dormitory supervisor the first week there: he was fondled and made to perform oral sex. This abuse continued to happen at least once a month for three years. He tried to disclose his abuse but was beaten by the principal. After the third disclosure he was nearly beaten to death by the man who abused him. He also disclosed abusive experiences for speaking his language. He argued that those who believe there is a minimal connection have not had these experiences within these schools. He pointed to Aboriginal prison statistics, loss of dignity and self-respect, loss of identity, Aboriginal people on skid-row, alcohol and drug use. Furthermore, due to the traumatic experiences of survivors in residential schools he stated that the term ‘safe sex’ is ‘absurd’ (p. 17). The seriousness of this letter prompted a discussion among the elders.

Mark spoke about the residential schools and how that experience scarred him. He sat there quite stoically, thinking back to when he was dropped off not knowing when he would see his parents again and being alone without having his siblings to protect him against the older boys who were the ones that mostly abused him. He remembered experiencing his hair being cut. He told us his own horrible story about how his face was rubbed in manure to explain why he has a hard time communicating. If that was not enough, he was also made to punch a steel pole until his knuckle broke and how these experiences made him “more physical.” Mark spoke about his drinking days and he explained that around the age of 40 was when he began to practice his culture. He joked about that time and how he was getting old and couldn’t beat people up anymore! Despite this dry humor, he had mixed feelings about the Church. He said although the quality of education that Native people received was poor and of the lowest standard, his disdain for that system has not kept him from occasionally participating in Church activities. We were left with the impression that attending the residential school was a very negative experience. It would have been helpful to learn more about why he still maintains some involvement or connection with the church even in view of the negative experiences.

Bernard then spoke up. He had a rare experience among people of his generation, in that he did not attend the residential schools. He talked about being raised in the bush. By the time he moved to the community he was 15 or 16 years old, too old to attend the residential schools. Bernard believes in the value of education and he has encouraged his children to go to school. Throughout his life he has worked and has not collected welfare because there was no welfare back then. He hunted and trapped to avoid starvation. He briefly commented on his drinking days but stated that he too stopped. He joked about how he would drink tomorrow. In my opinion, although he may have been unscathed by the priests and nuns, he still would have been affected by the fact that he would have missed out on playing with children his age since most of them were in the residential school. So it must have been lonely for him as a child without other children to play with and perhaps he had longed to be with other young people.

Then Helen spoke. She began by agreeing with Mark's comments about the residential schools. She stated that as a girl she learned many things at the residential school: domestic skills like knitting, sewing and crocheting. She said she would not have learned those skills if she had not been there. In my opinion, although there were some minimal positive outcomes of the residential school, the negative outcomes, like intergenerational trauma, outweighed the positive.

Although the core group members discussed sexual abuse amongst ourselves, when the elders joined us they did not disclose any sexual abuse because either they had not experienced it or it was too sensitive to talk about. Only Mark openly discussed the abuse he experienced. Within our group, it was difficult to determine a definite link between sexual abuse experienced in the residential schools and inappropriate sexual behaviour in today's generation. Although a direct link is not established between generations this does not mean that one does not exist. In my opinion, although people may state they were a victim of physical, mental, or emotional abuse, it is harder to admit to being sexually abused. I think it would be particularly difficult if you were a male speaking in front of the community's younger generation.

We were four weeks into the project and we had gone through the eastern door and southern doors of the Indigenous Iterative Webbed Circle. With kindness, we developed the morale of our group and planned to create a play. With honesty, we identified the issues for STI/HIV prevention. Still, we did not have a play developed. At times, it was difficult to find a balance between the social/ health context of STI/HIV that involved working with the elders and health care professionals, and focusing on creating a story for our play.

The end of May and the beginning of June were both positive and negative. There was tension mounting as one scene was created and the others were slow to develop. The popular theatre practitioner, Leila and Doug created the “Kehew and Pisim Story”. The story is about a young couple who were unfaithful in their relationship while under the influence of alcohol. Both characters were worried about being infected with HIV. They decided to stop drinking and work on their relationship. Leila and Doug were feeling very good about working with one another and were pleased with the scene they created.

Willow and Jasmine had other commitments with work and friends. With the pressing deadline, their absences created tension in the group because their work was incomplete. As four weeks had passed, the popular theatre practitioner began to feel a sense of urgency to create the entire play with all three stories of “My People’s Blood.” Again, the tipping tripod analogy applied to the scene development process. While the “Kehew and Pisim Story” was developed, the “Alix’s Story” and the “Savannah and Buddy Story” were not fully developed.

Once developed The Alix Story addressed the long term effects of unhealed child sexual abuse. Alix, a sexually abused child is unable to maintain a relationship as a teenager and young adult. Through a prenatal blood test she discovers she is HIV positive. Her baby is HIV negative. She becomes a spokesperson for AIDS awareness. The Savannah and Buddy Story is about the stigma of HIV. Savannah and Buddy were sexually involved in a non-committed relationship practicing unsafe sex. Buddy informs Savannah he is HIV positive. She worries about herself and rejects him. He discloses his HIV positive status to his friends and family but they do not understand. While drinking and driving he crashes his car and dies. After his death Savannah finds out she is HIV negative. His mother wants the community to make social change happen.

The tension of creating a play to meet a deadline, coupled with certain events, led to a confrontation between Willow and me. The lessons learned from this incident speak to the western door on the Indigenous Iterative Webbed Circle and the need to demonstrate caring for others when moving from analysis, to scenario making and/or improvisation, to reviewing the work. I received a call on my cell phone. Willow and Jasmine were calling to inform me that they would not attend group that night because they had a work related meeting to attend. When I conveyed the news to the popular theatre practitioner, she was disappointed. All of the group members went to school or work during the day and afterwards they were expected to participate in this project four times a week so what would otherwise be their spare time was taken. As everybody else in the group it was their choice to be involved and they had the option to quit. This of course left me in a precarious situation because I was caught between the popular theatre practitioner and these two group members. The purpose of the project was to create a play and I felt that if I said something to the group members about their attendance they would be upset and I did not want to create a rift. At the same time, the play needed to be created and this involved being committed to the project and working with the group and the popular theatre practitioner.

When I informed Jane about Willow and Jasmine’s decision, she asked me to ask them to come for a little while, so I did. Reluctantly, Willow and Jasmine did show up, albeit half an hour late and they left early, annoyed. The next morning Jane and I had a discussion in our home. We not only discussed the issues of attendance, commitment, and pressing time, Jane mentioned that my voice was dominating the process and I needed to step back to allow the core group members to articulate their thoughts and to allow her to facilitate the sessions. I thought we were a team but I felt like I was being pushed out of something that I had created. It seemed like a power struggle between her and me although we had the same goals. Her role was to facilitate the popular theatre process. My role of researcher/administrator was to observe, plan, take notes, and encourage the process. I thought I was doing that but she felt her role was being impinged upon. I felt a dark cloud hanging over my head and the feeling lingered as I questioned the validity of her statements. In retrospect, I have come to realize that the voice of the Indigenous researcher is just as important, as anyone else’s. My voice was important because I was able to link the historical consequences to the present day intergenerational trauma but at the time I stepped back. In retrospect writing about this allows me the opportunity to reflect on my own absent voice.

Even when most of the day had passed and it was time for group to start, I still had this uneasy feeling. It became apparent that I was not the only one who had a dark cloud hanging over my head. Willow and Jasmine chose not to say anything in the circle that Jane was leading so after everyone spoke, Jane focused on Willow and asked her if she had anything to say. On the second approach, Willow spoke up. Basically, Willow and Jasmine felt responsible for the group falling apart when they could not show up. They felt their presence was the glue that kept the group together. In retrospect, I would agree. Jasmine and Willow were key members of our group but it was not only their attendance that was important to developing scenes for the play; everyone's attendance was integral to the process.

I learned several lessons after having clashed with a co-researcher. First, choose a better time to discuss the issues. Second, deal with one issue at a time without adding another issue. Third, involve those who are impacted specifically; the popular theatre practitioner should have talked to the group members directly about it. Inadvertently, I was carrying the popular theatre practitioner's issues. Previously, the popular theatre practitioner would complain about being left alone to clean the facilities before and after each use. In an attempt to resolve this issue we had asked the group to come up with a plan to ameliorate the problem. While we were out of the room, they were supposed to discuss how to address the problem together. Willow took a leadership role and made the plan without much input from the other group members. Hers was a fast approach but it was not about consensus decision making and power sharing. I did not say anything about this principle of action research at the time, because it seemed to be a petty issue and we needed the time to work on scene development and popular theatre. Raising this issue in addition to voicing the attendance issue was like lighting a stick of dynamite.

Even after a break and apologizing I think Willow and I still felt emotionally wounded. We all came back to the class room and Jane kept busy working with the group members to create scenes because we were going to present the scenes to the elders and some of our invited guests the next day. I took a step back and removed myself from the process, wishing that I had done this before. A family member had reassured me that voicing conflict can bring a group closer together. I hoped it would.

The next day the atmosphere within the group was subdued. We had a circle with the elders and they gave strength to the group members. Willow wanted the elders to listen to them, the youth, because she felt that youth are not listened to by elders. Since we were not having gender-based talking circles, as originally planned, I prompted Willow to begin the discussion. She began to speak about her desire to become a role model who was willing to speak out about HIV. The clash from the day before renewed her resolve to become an advocate for STI/HIV prevention. After she was done speaking, Deidre and Helen gave her a big hug of support. Then the other young people shared their ideas. Nobody mentioned the incident the day before and although the atmosphere with the group was tense and subdued, the sharing and caring between the elders and group members kept us together. Willow's idea to speak to the elders and inform them of their goals enabled the elders to show their support of the youth and for the youth to feel their strength.

The scenes that had been developed were performed for the elders. The elders seemed interested and enjoyed the exclusive performance. The strength the youth received from the elders was a welcome respite for what was going to happen next.

A major decision was made as a result of a number of events over the course of the project. The group decided to undergo STI/HIV testing. This process is discussed in depth in Chapter Five.

For unknown reasons we lost two group members during the final weeks - after the testing and before the production. Engaging in this action research/popular theatre project and getting tested for STI/HIV was unnerving and required a backbone of steel. Maybe they left because there was too much community attention on this project and on them. It is difficult to determine.

The media had powerful – negative and positive – effects on this project. When I first contacted the Aboriginal radio station at CFWE my goals were to inform and recruit. To these ends, the experience of using the media was positive. However, when the group chose to use the media to inform the community members about the project, the local newspaper wrote a series of stories that were shocking and even disturbing. After having gone through the eastern, southern, western, and northern doors of the Indigenous Iterative Webbed Circle, the group became more involved in organization and action. The group wanted to inform the community about their research project and they decided to submit a letter to the editor. One of the underlying reasons they wanted the community to know they were involved was because they were interested in STI/HIV prevention. They wanted the community to know that they were not required to have an STI or be HIV positive to be involved in this project. With group consent, Willow and Jasmine drafted a letter to the editor and faxed it to the local newspaper. Subsequently the reporter requested an interview with me, the researcher.

Using an Aboriginal radio station for recruiting core group members was helpful and encouraging but using the local newspaper to promote awareness of our project was a double edged sword. One of the guidelines proposed by The Alberta ACADRE Network is to have ownership and control of the research findings. By answering the reporter's questions and having one's words in the public domain, the researcher loses some control over how the community is portrayed. One of the guidelines proposed by Ruttan (2004) requires the researcher to be aware of the social and political contexts of the research results. Politically, sending a letter to the editor with the intent of creating awareness to prevent disease and dispel stigma snowballed into something bigger, beyond what any of us imagined. It seemed that no longer was the focus on the group of young people who were trying to do something for the greater good, but on the numbers of people with the disease. Outweighed by the negativity of the community portrayal, our group morale plummeted.

This is my interpretation of the way in which the media portrayed the project and my perceptions of the core group and community's reactions.

The group members wanted to educate and inform the community about the project, and to identify their involvement along with that of the elders, popular theatre practitioner and the researcher. Twice, our group members sent a letter, drafted by Willow and Jasmine, to the editor of the newspaper. On their second attempt, they were successful in having the letter published. The letter outlined the problem as perceived by the core group members and invited the community members to the upcoming performance. They voiced the problem as follows:

> In our community, it is common that most people turn a blind eye when it comes to these sexual health issues. There are people in this community with sexually transmitted infections and HIV. They are shunned by their families and/or the people they love because we as a community have not come together to accept them nor their sickness….Sexually transmitted infections and HIV are a serious problem that we have to learn to deal with now, because it affects all of us [in some way]. We as a

> community need to come together to address … [the] issues that bring shame, hurt and heartache to all of us (Cardinal, C., 2005, p. 2).

They use the collective “we” to garner support for the problem rather than use the words “I” or “you” in their letter to their fellow community members to demonstrate their compassion for the people living with HIV.

We would not have had any media attention unless someone suggested it. Willow shared the idea and obtained the support of the group. She and Jasmine drafted a letter. I agreed to an interview with a reporter of the *Fever*, the local newspaper. I released statistics at the request of the reporter. The newspaper was released and this firecracker of information sparked a range of responses from two different community members. The feedback from these two community members reflects the diverse opinions about releasing data, and the image of the community, in the face of STI/HIV prevention. It was not my intention to portray the community in a negative light.

The information I shared with the reporter was prepared by the Northern Alberta HIV program. It indicates that in 2003 there were 34 cases in the community of less than 10,000. These statistics are comparable to that of the Ukraine or Estonia, not the worst areas for HIV infection globally, nevertheless indicating an urgent need for prevention. Even though the information is accurate, the headline of the cover page was in bright red and it reads, “HIV epidemic in Wabasca? Researcher says high numbers must unite community to fight HIV/STD’s” (Sinclair, 2005, p. 1). From my own perspective, I felt vulnerable, as if I was responsible for the content of the headline.

Even though the cover had a picture of our group in a scene that would have normally interested many community people, copies of that issue remained on store shelves. From my own observations, the newspaper sells copies based on interest in local stories. This time, with the headline screaming off the page, few touched it. After one quick read of the title, people chose not to buy the paper. If they had read the paper, they would have seen that the reporter included my quote about “drunk and high sex” factoring into the spread of the disease and the need for more HIV prevention, testing, and education. He acknowledged another statement I had made that not everyone engages in a high-risk lifestyle. He included my suggestion for more cultural programs advocating sobriety and the reinstatement of our cultural values with elders serving as role models. Following the story, the newspaper staff dug for a response from other community members asking them to provide their opinion by writing to the editor (p. 14). Interestingly, nobody responded in the following issues. Although HIV was a dirty public secret that nobody seemed to talk about, I thought one of the religious sects might have disputed advocacy of culturally-appropriate methods. Perhaps nobody disputed the story because it was too touchy. I think that the coverage frightened community members from buying the paper, reading the article, and having to think about it. In my opinion, it would have been better if people had read the story but it seemed that many did not want to face the reality of AIDS in the community and STI/HIV prevention. The media is a useful tool to promote awareness but even reporters need to be sensitive to the power they have to either frighten or educate people about sensitive health issues. Although this is my interpretation of this unexpected event, if I had queried the store tellers and/or the newspaper staff about sales, then I could better support my theorizing.

Seeing the stack of newspapers made me feel like I was in a ghost town, with people saying very little and shying away from me and for a moment in time. We were like an outlaw group of bandits doing the wrong things for the right reasons. In retrospect, an alternative to using the local newspaper would have been to publish a flyer and release it through Canada Post, thereby maintaining control of the messaging. I carried my weary and worried self to an office in the community to be amongst other “health warrior[s]” just to learn that not everyone is of the same Indigenous mind when conducting STI/HIV prevention (Cardinal, J., 2004. p. 6). An administrator confronted me and asked me to sit in his office as he voiced his concerns about the article in the newspaper and how the leadership might react. His concerns were upsetting and I called Jane to come and sit down with us. That night at group in our talking circle, Jane explained this moment with the core group members. She said:

> We had a big shake at the ____ with ____ and that was kind of fun (*laughs*). Josie can tell you more about that. This was very exciting and that was a great moment actually, it was a great victory and yes some people are negative but there are people who are so excited and so pleased that you guys are

> taking this on. I was able to say _____ have some courage and have some hope and have some confidence in the youth in your community (June 30, 2005)!

It was upsetting for our young people to hear this because they were on the verge of performing for the community. Even though being confronted by the administrator was upsetting, the confrontation brought those of us who were strong and committed, closer together. My family member was right - we had become a unified group. Rocky, one of our group members was particularly offended and wanted to know who this person was and why he did not have any confidence in our group. There was nothing to suggest that the administrator did not have confidence in the youth but he was concerned for us and the ramifications the news coverage would have on the community's image. Jane identified the person and told the group that even though he has some authority, the funds for this project were not band funds. She stated:

> He was just shaken. I said, what is the worst that could happen? He said they will throw you off the reserve. I said, GREAT, I am ready to go! I didn't say anything, he just saw the article and got very concerned and that there was going to be backlash and Chief and Council would be all upset; and Josie and I were going to be rolled and tarred (June 30, 2005).

Now that Jane had caught the attention of the core group and they were aware that something had happened, they wanted to know what was going on. We were in a crucial stage, less than two weeks away from performing. Rocky expressed his determination to avoid letting someone's opinion drag the group down. He responded, "We'll put so much jam on that stage that we'll make them all cry!" and Jane agreed. It felt as though there was not much more that the group could take and I wanted to let them know that not everybody is fearful.

At this point, I responded to this discussion. I relayed to the group what had happened and how if we let fear sabotage our efforts we may lose our opportunity to deliver a message about STI/HIV prevention. Then, Willow spoke up, "You can move off the reserve and move into the MD of opportunity." I knew at that point, that she cared. In reference to the Indigenous Iterative Webbed Circle, Willow was exemplifying caring by offering shelter. Rocky and Willow defended our group by providing encouragement and protection.

This verbal attack brought us closer together and it made the group more determined to see the project through to completion. In retrospect, as we tried to raise awareness of a health issue, the approach we took to achieve our goals could have been punishable if the leadership chose to remove us from the community or if our funds were withheld by the Department. However, this risky action served to unite the group and increase determination to perform. Action researchers are in precarious situations. They can be subject to oppressive actions by an unwritten law of conformity or banishment. Although we were not forced to become refugees, we felt like righteous outlaws, trying to prevent the spread of a socially stigmatizing disease.

I let the group know that while there was this negative feedback there was a positive comment too. A community member who also had an article appear in the paper stated that he liked the interview and my comments. After the day I had had, those words were the salve to soothe my pain. After finding a solution to the possibility of being asked to leave the reserve and relocating nearby, Rocky directed the group to focus on the rehearsal and they did with heart and soul.

People in the wider community found compassion in their hearts and they began to recognize that we were going to produce a performance even if no one showed up. We were determined to see this through no matter what. What we were doing was for the community and for the unborn children and future generations to prevent STI/HIV. It was real and it was important. People began to come forward when asked. One by one they came with lumber, hammers, lights, sound equipment, and feast food. The community was mobilized! Community mobilization is an important indicator of the support that community members were willing to provide for the researcher, the STI/HIV prevention project, and the group members. The type of support that we needed involved obtaining supplies and labour to prepare for the production.

We were five hours from the nearest major city, where the expertise to build stages, provide lights and sound was available. The focus of my research had been on observing and interacting with the group as they created a play so up until two weeks before the scheduled performances, not much thought was given to the logistics of producing a finished performance. With prompting from the popular theatre practitioner whose efforts to locate equipment and recruit volunteers was to no avail, we began the pre-production phase. Rather than import the supplies and labour, we decided to find the goods, services, and labour within the community. I did not expect people to volunteer because I had the financial resources to support the local economy by hiring community people to help provide lighting, sound, a stage with screens, and women to help prepare a feast.

In a First Nations community, people are criticized for nepotism but when the community is smaller than a city, you are bound to work with your close or distant relatives. We were piecing together everything in order for the group to perform. One of the calm moments before the production happened on a trip down a gravel road to meet a local angler who happened to be a distant cousin. I introduced myself to him through the lineage of my parents and explained the purpose of the project. After I gave him some tobacco and a gift, he agreed to provide smoked fish for the feast. The tobacco was a cultural way of asking him to provide smoked fish for our gathering. I felt exceptionally good about supporting the traditional Indigenous economy through this form of trade. On a rainy day a few days later, I drove down the muddy road to his place and he was in his smokehouse, a makeshift tipi, gutting the fish and hanging the fillets to dry. He made it look so easy, as if he was buttering bread. Even though it continued to rain outside and the roads were muddy, nothing was going to dampen my spirits. I felt so blessed to be able to serve Indigenous food for the feast.

A week and a half before the performance the group lost two members. The three stories for “My Peoples Blood,” were developed but getting all of the group members together to rehearse still remained challenging. Thirteen working days before the date of production Doug’s attendance started to falter. He missed four days in a row. That week Leila’s attendance became sporadic, too. I felt a loyalty to Doug and Leila who worked so hard at the beginning and during the middle of the project, but when they failed to attend, my loyalty to them waned.

The core group members wanted to perform without them. Willow, Jasmine and Rocky were bolder about making decisions and tensions escalated. Without group consent, Willow and Jasmine tried to pass some acting roles to the new recruits, Byron and Rae Anne, without consent of the entire group. Recruiting had been talked about but a clear group decision was not made because the popular theatre practitioner and I hoped that Doug and Leila would perform the scene. The group's indecision caused Byron and Rae Anne to not come back.

Leila objected to her role being given away. This was more than an argument about acting roles; it was about strained family relations. As they bickered over roles, I advised and encouraged both young women to earn respect and self-esteem by following through on their commitments as they are the ones whose names appear in the paper. Not only was their integrity at stake, this period in their lives was something that they may reminisce about in the future and either they will feel good about it or not. I touched a nerve and Willow started crying. Leila showed up the next day. Doug still did not. We did not see Leila after that. She told us that she was bored, confused, and emotional. Byron and Rae Anne came back to fill the roles left behind by Doug and Leila.

It would have been the perfect time to bring in the elders for their encouragement and strength. Even though I encouraged it, it did not happen. Before the round dance, I had mentioned the idea of having a second sweatlodge ceremony but we did not discuss it further. It would have helped us. I presented cultural protocol on behalf of the group. This was the group's response:

Josie: I wanted to know if anybody wanted to have a sweat on Saturday. It's going to be over at Mark's place on Saturday at 2.

Jasmine: I want to take a day off.

Josie: Is anyone interested? It will be on Saturday [July 2] at two o'clock for our group.

Willow: Was this planned?

Josie: I had mentioned it before but there was lots going on before the round dance.

Willow: Can you postpone it?

Josie: Tobacco has been offered.

Rocky: It's the same weekend as the rodeo.

It was the group's decision not to attend but I forged ahead. It was the end of the month and we still had one more duty to complete, the Canada Day parade.

Fatigue was starting to set in and I did not feel like participating in the Canada Day parade. I wanted to sleep the day away but there was a parade happening and our group had decided to be a part of it to promote awareness of the project and invite the public to the performance. Originally, Jasmine had wanted to enter a float but she did not follow through on planning for it. I did not really expect her to because our group had enough to worry about other than make a float. We wore masks that we made and we walked through the main street of the community, handing out one hundred bags each filled with two condoms, information from the Ribbon of Hope Committee,[51] an HIV ribbon, and an invitation to the upcoming play. Participating in the parade offered the group members another empowering opportunity to advocate for STI/HIV prevention to increase the community's capacity to discuss this taboo subject.

The sun was trying to peek out of the clouds and we began to have some fun. Before the parade started, Jane was taking pictures of our group by the health center and the health center staff members were busy putting more red and white balloons on their float. I kind of wished we had a float, too, but we were not there to win a float contest, we were there to extend an invitation and deliver a message. Then, in Canada Day parade spirit, the health center staff began shouting their mantra: "Give me a C," and Jane and I shouted "C!" Give me an "A" and Jane and I shouted "A!" This went on until the lead person finished spelling CANADA. "What do you got?!" they shouted. Then Jane and I looked at each other and in the spirit of STI/HIV prevention, we shouted in unison, "CONDOMS!" They did not seem to be as amused as we were. Then our group continued onto the business of gleefully handing out the little bags to parade watchers.

For the most part, everyone came back relaxed after having one day off. Diane, one of our group members, came to group carrying a burden that she wanted to share. She was very worried about a friend

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[51] The Ribbon of Hope Society is a committee comprised of several community organizations formed to understand and determine the needs of people living with HIV.

of hers who had HIV and whose health was declining. She expressed her worries to us and shed tears because that friend was someone she had grown up with. This was Diane’s personal reason for being involved in this project. She wanted to deliver a message to others about the urgency of preventing the further spread of this disease that claims lives because her friend had the virus. Even though the group was excited to perform for their community, Diane brought the group back to reality that HIV/AIDS claims lives and the significance of HIV prevention.

In addition to the on-going rehearsals, two days before the event those of us who were involved began to resemble a hive of bees swarming to complete the following duties:

1. Create a PowerPoint presentation of pictures of the project to display as people waited for the blessings of the elder before the feast.
2. Borrow a projector, assemble the screen and laptop.
3. Compile a radio ad and advertise the production.
4. Ask the local health centre staff to help create posters and pamphlets for the production. They agreed.
5. Recognize the volunteers and supporters in the pamphlets.
6. Confirm the attendance of the Ribbon of Hope Society to provide HIV information and give away door prizes.
7. Decorate the gym with rolls of newsprint illustrating the storyboarding technique that was used, in part, to create the stories for the play.
8. Set up round tables with chairs to fill the gymnasium.
9. Assemble the stage, lights, and sound.
10. Invite someone from the community to operate the camera equipment.
11. Decorate the screens with masks the group had made.
12. Cook the feast food.
13. Invite the elders.

Many people from outside the core group helped and, by becoming involved, declared their desire to make a change in their community.

After helping to set up the PowerPoint projector, Diane’s son, Nathan, travelled with me to a local store to buy tape for the camcorder. Driving along the main road, one could see the ruins of the residential school. Diane’s son and I noticed the construction crew was continuing to demolish the last part of the building, a horrific place for the survivors, many of whom experienced sexual, physical, emotional, and spiritual abuse. The irony was as thick as the heavy grey rain clouds. In the clouds above the community, a funnel was appearing. There was no time to worry. I was too busy to stop and observe. Determined, I continued to drive to the local store to buy the tape for the STI/HIV prevention production, “My People’s Blood.”

It was raining when we arrived back at the gym. Inside the school gym the staff from the women’s shelter had set up the food on long tables. The aroma of smoked fish filled the air. A raised stage made from pieces of discarded building scrap was screwed together by volunteers. A long piece of red satin was used as a skirt to cover the hand-made stage. The red colour was symbolic of the play, “My People’s Blood.” The stage had three flats in colourful hues standing on it; masks gaily decorated the flats. Our lighting and sound people had set up their equipment. Round tables filled the gym floor. Our group’s drawings of characters and STI/HIV brainstorming lists, written on big sheets of newsprint, were taped to the gym walls for community members to view. People arrived, sat down, and watched the slides of our process as they waited for the evening to begin. Our group of Indigenous youth were nervously preparing to perform the play for their community. Approximately two hundred people attended.

The elders sat together, dressed up for an evening of traditional food and community theatre. That evening we were rich with culture and life. Alice Reid, a community nurse and elder, was asked to conduct a prayer for the feast food and evening. She accepted the tobacco. The elders lined up first and guests and community members followed. The elders who supported our project seemed very happy.

Out of respect for the Chief and Council who attended, I asked Chief Francis Gladue to speak. He addressed HIV from the historical perspective of the effect of infectious disease on Aboriginal people. He reminded the audience of smallpox, tuberculosis and influenza. HIV is the next epidemic to affect Indigenous people and others, globally, he added. Then it was my turn, to introduce the project and the play. Behind the stage the group held hands tightly in a circle and quietly cheered, “1, 2, 3, condoms!” The lights went down. The stage looked brilliant. They were on. They performed fabulously.

Chapter Five: STI/HIV Testing

As an Indigenous researcher engaged in STI/HIV prevention using popular theatre and action research in an Indigenous community, my goal for the core group was to deliver a STI/HIV prevention message to the community. As the research project began, STI/HIV testing had not been anticipated. However, through consensus decision making the core group agreed to go for STI/HIV blood testing. This led us on a huge action research spiral that required more determination and will than some of us had. STI/HIV testing was a direct outcome of this community-based project.

Before going for testing, we discussed in detail the social issues of alcohol and drug addictions that can contribute to possible contact with the bacteria and viruses that cause sexually transmitted infections and AIDS. This conversation stemmed from early discussions that reached back to when we first began talking about sex and STI/HIV and the factors leading to the spread of STI/HIV. Similar discussions around these factors also surfaced when we were storyboarding to create the backbone of the three stories which formed our play. These discussions prompted consideration of the emotional impact of being STI/HIV positive. Alcohol, drugs, sexuality, ethnicity, and gender are ingredients for the cocktail that produces shame, particularly among Indigenous women.

Although we were engaged in a very sensitive topic, the people I worked with were not the vulnerable population that seems to be so weak and fragile as to crumble like a piece of hardened dirt; they were a group of people who shared their personal experiences with honesty, courage, and determination in order to address STI/HIV prevention. By contributing and staying with the project they demonstrated their commitment and concern about this social and health issue. They were not the apathetic sort of people, who when stricken with grief and powerlessness, avoid the issue. Below is my interpretation of the data from the talking circles, logs, flipcharts, and journals. Based on the results, I added my own critical reflections on sexuality and the role of colonialism on Aboriginal sexual identity.

A presentation to the group by the Ribbon of Hope Society was facilitated by one of their committee members. Ribbon of Hope has representation from the Aspen Regional Health Authority, Bigstone Health Commission, Peekiskwetan “Lets Talk” Agency, St Martin’s Medical Clinic and community members (Auger, D., 2004). This committee formed because there was a growing population of people living with HIV/AIDS in the area. Their challenge was to promote awareness and provide support to the community to prevent or at least decrease the spread of HIV (Auger, D., 2004). I felt it was important to work with Ribbon of Hope so I invited Shelly Gladue a committee member and nurse to present on STI/HIV to our popular theatre/action research group.

Shelly Gladue's presentation focused on the transmission of HIV, the signs and symptoms, testing, and prevention. The nurse spoke about mother-to-child transmission, sexual transmission, and through other body fluids. Although sharing injection equipment is a primary vector in urban centres among the co-researchers of this community it was not an issue. The Indigenous nurse spoke about the importance of HIV testing and how it was also important to be retested after a six-month window period from the initial date of testing. Willow reacted. Willow had gone for HIV testing before joining our group and her result came back negative but apparently she had not been informed by her doctor that she was supposed to be retested six months later. The nurse was slightly dismayed because she had asked the local doctors to encourage their patients to come back for a six month follow-up. Everyone continued listening to the nurse's presentation. Although it wasn't immediately apparent, Willow's reaction would influence our project in a major way. It was as if a small grass fire had flared up; we didn't know if the fire could be contained or if it was going to spread.

As we left that Wednesday with the promise to meet again on Sunday, the grass fire continued to burn. Nobody did anything about it or said more, not right away. Afterwards, in casual discussions, the concern about testing resurfaced. As usual, the popular theatre practitioner and I had a lot to mull over after group. I could not stop thinking about Willow and her regrets about unsafe sex and worries about HIV. I proposed a question to the group: as a group, do you want to get tested for HIV? They must have felt the same way I did and at that moment when they all agreed I felt like we had become a community – united for a common purpose. There is a stigma about having HIV, that getting tested for this disease draws unwanted attention to a person. They felt it was safer to go as a group rather than have anyone become the subject of gossip by going on an individual basis. STI/HIV testing was an important theme in our work on two levels. On a personal level, the group chose to support one another by collectively testing for STI/HIV. On a broader level, they decided to educate the community about HIV testing in the plays that they would continue to create. A couple of days before we went for testing, we had a talking circle, reiterating the possible factors leading to the spread of HIV. This time, I focused on the role of alcohol and drugs in the spread of STI/HIV among community members. Jasmine initiated the first response. She talked about some people she knew who smoked crack cocaine everyday and would do anything to get high including selling their body for it. She thought how easy it would be for a person who had an addiction to contract HIV and spread it to other people. She said:

> *I'm so happy that I didn't get that far! I didn't get that frickin' [addicted] and it's pretty weird how when I think about it now and how long I smoked, almost everyday. We had lots. We spent fifty bucks for a half between three of us and when I think about all that cash spent there, and so many different ways other people keep buying to pay for it.*

Prostitution or trading one's body for crack cocaine was something Jasmine did not do to get high.

In previous discussions, we had spoken about kids using crack so I brought that up to get the group thinking of how addictions can also claim the lives of even younger people, because in my opinion, having an addiction and losing control is the main problem. Jasmine reasoned that if kids are smoking crack then their parents or guardians must be smoking it, too. Rocky interjected that one's peers have a large influence on drug use. Jasmine responded that young children will model what they see; if an older person that they look up to smokes crack then those young persons will do the same. It seemed that she did not want to completely disagree with Rocky so she clarified the age factor, saying, "kids just don't grow up wanting to smoke crack." It was good to see that Jasmine and Rocky were willing to disagree in front of the group on this topic. The points that both Jasmine and Rocky were raising were valid; first time crack users might be modeling the behaviour of their parents, peers, or older people. I pressed further.

I wanted to direct the conversation to a more personal level because I cared about them so I asked all of them, "Why are you people using drugs? What are the reasons that people are addicted to crack?"

Rocky answered the less personal, second question, and said that he knew an eleven year-old boy who smokes crack and he thinks it was his friends that got him started. Jasmine spoke about her own drug use and said her reason for using crack was to get a different high. Rocky said that when your friends are doing it too, it makes a big difference. For Jasmine it wasn't because her best friends were using crack, it was her cousins that she was hanging around with that were influencing her. She reflected on the period of her life when she was smoking crack:

> *There's just some stuff that you don't want to get into and don't bother at all because it takes you, just like that in a snap of a finger. It's easy, anyway for someone as weak I was anyway.*

Through telling her lived experience of using crack and overcoming it, she was warning others not to use it. The popular theatre practitioner pointed out to Jasmine that it takes strength to overcome drug use. I admired Jane for saying that because it was good to hear Jasmine talk so openly about her experience. Other group members began to participate in the conversation.

People become addicted to something "when they feel like there is no point," said Willow. She went onto say that even when someone knows they are addicted they will try to overcome their addiction or not. This depends on the circumstances and whether or not they have personal goals, or whether or not they have family support. People who become addicted can get HIV and pass it on to other people through casual unsafe sex "because you don't care about yourself" said Willow. Rocky added that if a person has the money or is willing to trade their body for crack why should they care? "You're not breaking your pockets," he said. The idea was that since sex and drugs go together it is even better to have sex with the drugs than to spend money. Rocky was thinking as a user who wanted to save money would, to get high, to demonstrate why people would resort to trading sex for drugs. Jasmine said that it was the same situation with alcohol and Leila agreed. Jasmine said:

> *Same with alcohol when you're drunk, you don't care. You don't [care] - you don't mind all the hurt. You don't stop and think, "You're not putting a condom on!" You're thinking of I want a hoot or whatever.*

The popular theatre practitioner examined the situation from a broader perspective: “It is really common for young people, to have drunk and high sex because you don’t have any inhibitions and you’re not thinking about it.” “People are thinking about the moment and not about what will happen later,” said Willow. We were beginning to smell a reek of smoke from a grass fire and it was a warning to watch out for danger.

Willow began talking about the uncertainty of her HIV test results. She regretted not having safe sex “because now I don’t know if I have HIV or not or whatever and I’m sure I don’t have STIs.” Willow had an HIV test in October of 2004 but she was not told she had to go back for a six month follow-up test. She stated:

> *I live with that worry now and I regret it. I can honestly say I regret it. Now that I am older, I am twenty-three, now I realize [how much] I didn’t care then, I was young. I didn’t think about my future. I honestly didn’t think about my future, I only thought about now. I didn’t think about it. I only started thinking about my future last year when I started taking that [Skills for Life] program and I started realizing that there is so much more to life than alcohol and drugs.*

I should have said something to Willow to comfort her but all I could do was watch the grass fire burn as it got increasingly close to us. I was mesmerized as when watching a fire crackle and burn; you keep watching until the fire is getting out of control or too hot before you do something. I was on my fact-finding mission trying to find out more about factors that lead to the spread of HIV. I was on the action research spiral. Little did I know at the time that we were going to take a huge spin.

The conversation continued and Leila started talking about how alcohol has affected her life. Leila is on medication to manage her mental health and she experiences blackouts when she drinks. She stated:

> *Alcohol is the worst because I never remember what I’m doing. I am told that I have to quit because the medication that I am taking makes it worse. If I am sad when I am drinking it will be ten times worse. If I am happy, I am over excited. And I don’t know. I have tried to quit drinking. I quit for*

> *about a month and then I started up again. I don't want my car taken away. I don't know. It's weird. I think about everything now and about what could happen to me.*

Although she has tried to quit drinking, she hasn't been entirely successful. Maybe it has to do with her attitude and behaviour towards quitting. She tried to be a designated driver to avoid drinking and losing her vehicle. The popular theatre practitioner tried to guide her to think about the consequences of engaging in risky sexual behaviour when she is drunk. The popular theatre practitioner and Leila had different ways of thinking about drunk behaviour and outcomes. The conversation was a little stormy and although Leila did not say to the group that she engaged in risky sexual activity when she was drunk, the conversation was on factors leading to HIV and it raised an interesting point. It seems that it is more socially acceptable to admit alcoholism and to avoid using alcohol because you don't want to lose your license than to admit alcoholism and to avoid it because you don't want to get STI/HIV. The stigma associated with being an alcoholic female becomes even greater when one is Native; add STI/HIV issues and one finds oneself in a very shameful dark corner. It is not that sexual activity is bad. We are sexual beings designed to procreate, but somewhere along the line being sexual becomes equated to sexual promiscuity, a term laden with social values that reach back to colonialism. Being recognized as a sexually promiscuous female while under the influence of alcohol prompts judgment and labels of "slut," "sleaze," "whore," "skank" and sometimes "squaw."

It is true that alcohol/drugs, sexuality, ethnicity, and gender, are ingredients for the cocktail that produces shame. In North America colonization, cultural genocide and alcohol have degraded the roles of Indigenous peoples. The majority of mainstream society is not aware of the full effect that colonialism has had on the identities of Indigenous peoples. There exists a morality within the mainstream society that all segments seem to be measured up against. When someone is not part of the dominant group then they are further scrutinized. The settler society imposes its judgment on the peoples they have colonized as a further means of oppression through discrimination and racism. Not being able to name that negative experience or do something about it prevents healing, it is oppression. I wanted to say all that to the group members in that moment but I just listened.

One purpose of this process was for them to become critical thinkers. Maybe they would have expressed post-colonial thoughts to me if the popular theatre practitioner had not been there; she is a White woman so perhaps they did not want to offend her although she probably would not have objected to naming the situation. So, we continued to talk about other dark and depressing topics that exist, like pregnancy and giving birth to a FASD baby and the life long hardships for mother and child because of drinking during pregnancy. Jasmine talked about women who use crack during their pregnancy, “Some of them they don’t give a s___ either, even if they have a little someone in their belly like you know?” While Jasmine was starting to get a little unnerved about the issue, Doug added that, “If the baby is born with FAS then they’re just making their life harder, too.”

Jasmine questioned whether or not spreading awareness was enough. It was a very critical question and it could prompt action towards other methods of HIV prevention, developing healthy public policy, getting people tested, healing addictions, and relearning cultural roles and passing that information to other Indigenous people. It was clear to me that this group was thinking about social issues and their own issues. I wanted them to know that I regarded their participation highly. I realized something very important as I listened to them. There are other people within the community who are even harder to reach. By demonstrating that level of commitment and concern, this group was showing that they cared about their community. We identified many problems and it made me ask them one more question: why don’t we have more mental health workers, youth workers, programs, and money to hire more people? There were no answers.

Willow was becoming emotional and reflective. She was worried about not knowing if she was HIV negative. In her journal for that same day, Willow wrote:

> *Wow today was a good day! I really enjoyed our talking circle today about how drugs and alcohol play a role in the effect of HIV/STDs. It’s nice to hear everybody’s thoughts and opinions about it. I feel really strongly that it depends on how we were raised as children, whether we were treated well by getting all the necessities that children need growing up, or if we were raised poor with alcohol parents or drug addicted parents, it really depends on how much love and affection you give to your*

> *children as they grow up. The love should be there right from the moment you're born, to the day you die. Expressing your love by saying it or hugging your children regularly is so important in the foundation of how a person grows up and is social with other people, and how much they love themselves. So if a person really, really, loved themselves they wouldn't choose to live such high-risk lifestyles. All anybody and everybody wants is to be loved, to be loved by their parents, or just by anybody for that matter. A wise, open-minded openhearted, sensitive, loving man, once told me that love makes you free… it comes back to the factor that people sometimes don't care about themselves because they weren't loved enough when they were growing up…We need to start loving ourselves and start realizing that there's a future for all of us.*

Her journal expressed how she has come to realize the importance of love and self-love to avoid STI/HIV.

It was because of Willow's courage in expressing her concern about being HIV positive and my suggestion to get tested as a group that we discussed the role of alcohol and drugs in the community. Using these methods empowered the group to test collectively. With the help of Shelly Gladue, who contacted the local doctor with our request, we were able to see the doctor as a group and get our lab requisitions. All group members arrived at the doctor's office to have the STI/HIV blood testing procedure explained by the doctor, who also informed the group about the process of obtaining our test results. To maintain confidentiality between the doctor and patient, our results would be given to us individually. Our group agreed that we would not share our individual results with the group. The doctor then gave each one of us a lab requisition and the group went for STI/HIV testing at the local hospital. From there our blood samples were sent to the provincial laboratory.

The lab technician wondered why so many of us were testing for STI/HIV. We informed her of our project. We waited two weeks for the results. Although some of us had been tested on other occasions, for others it was their first time. I was concerned about the effects of the stress of not knowing the results for two weeks and the possibility of a group member having an STI/HIV positive outcome. In that moment, testing seemed like a good idea. We cared about one another and our own health, but given that we were also trying to promote a message within ten weeks, the timing of the testing threw us for an action research spin.

After the testing that day, we met at the Old School. Leila arrived late and the mental health therapist did not join us for that evening session. In their journals some of the group members wrote about their HIV testing experience and others did not. This is what they wrote about being tested:

> *All of this jazz about getting tested made me realize, [Leila] you really need to respect your body, it's the only one you have. I am going to pray that [no one] in the group has HIV. My friends need to be more aware too. I feel like spreading the word. - Leila*
>
> *Today was an up/down day for me. How about you? The HIV testing was scary for me at first and I also felt happy that I was getting tested. A part of me knew that it's something that I needed to get done. Even though I feel positive that everything will be okay, there's that fear of the unknown that it's possible I could have it. My world would come crashing down on me so hard! It makes me angry that I did the things I've done to people in the past and to myself. I can't think like that though. I have to remind myself that everything will be okay. I hope everybody else is okay too. - Willow*
>
> *I understand that people get scared to go and get "checked," but that's understandable, even I thought about it, but I understand that sooner, rather than later that I would have too, anyway and it just seemed like a regular shot like a flu shot, or TB shot, except this is where they withdraw blood and check. I think everyone should, especially the sexually active ones. - Doug*
>
> *I'm glad that we got our HIV/AIDS test today but I'm kind of nervous of what the results are going to be but [I'm] looking forward to them. - Rocky*

The group had decided that they did not want to talk or think about their test results so we did just that, we avoided the topic. But by the end of the project a group member disclosed to the community audience how the process of testing affected him and how group members stepped forward to become advocates for STI/HIV prevention and testing (See Chapter Eight). After testing, the popular theatre practitioner focused, and focused hard, on creating three plays, plays with a message (See Chapter Six).

CHAPTER SIX: SPIDER WEAVING TOWARDS DEVELOPING STORIES

Spider Woman is a significant creator of the web; the silken spider weave woven into the dream catcher is a metaphor that is used to shape the tone of this dissertation. The intent of the dream catcher is to remove bad dreams that happen in the present. In the case of STI/HIV prevention the discussion of negative events or experiences related to sexuality were not pleasant. For instance, the stigma of HIV, cultural oppression of sexuality, and violent experiences based on gender and social roles prod readers to reach across the cultural divide into the web, to understand the content of the stories created by the co-researchers. The purpose of the dream catcher is to connect the thoughts and stories together. It allows me to connect the contemporary struggles to be human and sexual in an Indigenous community that is impacted by STI/HIV with the challenge of creating a play with a message on prevention. I transformed the dream catcher, creating an Indigenous Iterative Webbed Circle in order to share the process of story development. With understanding and a sense of empowerment, individuals, families, communities and the nation can move through the open space of the dream catcher and open the channels of communication. By identifying the strengths of the three stories in “My People’s Blood,” readers can respond to the voices that created the STI/HIV prevention play and examine stereotypes. This is my effort to weave together fact and feeling to provide a measure of meaning while addressing this sensitive issue. Before providing my analysis of the story development, I explain the use of the dream catcher symbol and introduce Spider Woman.

Using Inter-tribal Cosmogony for Story Development

Writers who use mythology may be subject to criticism by analyzers who tend to disprove myths as “the falsely obvious world of mass communication” (Abercrombie, et al., 1988, p. 161). When a myth is defined, boundaries and barriers are erected; this should be avoided so as not to “limit myths to stories involving supernatural beings” and to “raise religious questions” (Doniger, 1998, p. 1). As Doniger (1998) states, a myth is a tool used by human beings for different purposes and defined by different human beings differently (p. 2). “A myth is not a lie or a false statement to be contrasted with truth or reality or fact or history," although it is usually contrasted to truth. Instead, a myth "[i]n its most positive and enduring sense," should be thought of as "a story that is sacred to and shared by a group of people." They outline important concepts that are believed to have happened or will happen in the future (p. 2). Doniger (1998) thinks of a myth as part of a visual spectrum in which the metaphor of microscopes and telescopes "epitomize the extreme ends of this narrative vision" (p. 7). In essence, a myth hovers between the highly personal microscopic level and the telescopic level that is more abstract, theoretical and perhaps mathematical (Doniger, 1998, pp. 7-8). Essentially, using myths requires one to "change the scale in which you view any particular phenomena" from the microscopic to the telescopic views (p. 10).

There are many diverse Indigenous myths regarding the cosmogony, the creation of the world or universe, and each story is shared, accepted, and believed to be true by the Indigenous people. It is part of their cultural identity and allows Indigenous people to "eradicate social domination through self-identification, cultural definition, and cross-cultural communication" (McBride, 2004, pp. 426-428).

As a Cree researcher from this community who is writing about the story-development process on STI/HIV prevention using popular theatre and action research in an Indigenous community, let me state that I am writing for my community and on behalf of several audiences including academics in the fields of public health, theatre, and Indigenous studies. For the record, I am aware that I am using an inter-tribal symbol. The dream catcher, something that was originally created by a spider, is now a tool that links cosmogony from various tribes to the task of describing story-development.

The Cree of Northern Alberta, the source of my own cultural upbringing, hold similar beliefs to other Cree nations in regard to respect for humans, animal spirits, other spirit beings and above all God or Creator (Adelson, 2004, Black, 1977, Feit, 1986, Tanner, 1979). Among the Cree, large edible animals and smaller edible animals are more highly revered. Hunters demonstrate respect for the edible animal they have killed because the animal has given itself to the hunter and a cycle of reciprocity is established (Adelson, 2004, p. 70). Although spiders[52] are not eaten they are considered a protector.

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[52] The dreamcatcher is considered, by Cree people, to be a protector.

Traditional stories from the Cree perspective generally focus around Wesakecahk[53] who is a central figure in Cree stories. When we were developing stories into a play, the popular theatre practitioner introduced the idea of weaving stories together in a collective creation using some of many methods. She mentioned that Native Americans have created something called spider weaving. Spiderwoman Theatre started as a workshop in 1975, by three Native American sisters in New York City. It has since become "the longest running feminist performance group in existence" (retrieved July 3, 2008 from http://staff.libmuohio.edu/nawpa/origins.html). Taking the suggestion of the theatre practitioner, I introduce the Indigenous Iterative Webbed Circle, a human-made model that combines health, popular theatre, and action research concepts to analyze the story development of the STI/HIV prevention project.

Spider Woman has been described as the "quintessential spirit" who is a powerful intelligent spirit who is capable of song, radiant movement, and moving in and out of the mind (Gunn Allen, 1986, p. 13). Her alias is Serpent Woman and there are many incarnations of her including Corn Woman and Earth Woman. They have helped to create life on Earth (p. 13). An important distinction that Gunn Allen (1986) stated is that:

> Her variety and multiplicity testify to her complexity: she is the true creatrix for she is thought itself, from which all else is born. She is the necessary precondition for material creation, and she, like all of her creation, is fundamentally female – potential and primary (14).

Indigenous women who are articulating the experience of colonization and its effect on Aboriginal sexuality to prevent STI/HIV recognize that context is important to understanding our stories and part of that is both "ritual and historical, contemporary and ancient" (Gunn Allen, 1989, p. 2). We, as a people, continue to survive despite life-threatening diseases and our context becomes historical and tribal. The Spider Woman story has been used in public health to demonstrate the interconnected framework that enables people to support good health across the lifespan (http://www.pubmedcentral.nih.gov/articlerender.fcgi?artid=1832128). In spider-like fashion, I connect

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[53] Wesakecahk works for Creator and is known as a teacher to human kind. In his role he is a trickster/transformer.

the stories around STI/HIV prevention in a Northern Alberta community by connecting thought and action within the web that includes aspects of the individual, family, community, and nation.

The Truth about the Truth

During this research project, part of the group building exercises included talking circles. We had a talking circle initiated by the popular theatre practitioner on the topic of nudity. She wanted the group to respond to a thought she had about how the media portrays the ideal feminine or masculine body in juxtaposition to the average female body. She explained that:

> *When do we see naked women, besides ourselves? If you're a lesbian obviously you see your partner but if you're not, you see naked women in pornography and models and all those perfect women. We don't see ordinary women. We don't see women who've had children and what their bellies look like, you never see women who had hysterectomies or caesarean sections. We just don't have those images.*

The probing question received a reaction - that womanhood is associated with violence.

In our talking circle on gender, nudity, and sexual awareness, not everyone spoke, but these were some of the stories and comments that surfaced. One of the older females in our core group started to answer the question.

> *Nicki: I don't know. I was always around my mom and my kokums.*[54] *I was brought up that way around elders, cooks, teachers but I also seen the bad side of it too, which I thought growing up, [was terrible]. I used to see my mom getting beat up [by my step-dad] so I used to take that as [she paused]*
>
> *Researcher: How was that for you?*
>
> *Nicki: I always told my mom that I wasn't going to let that happen to me…For a long time it was like that. I guess in a way I kind of thought it was, not normal but I saw that and I hate to say that I was hoping not to go through that way, but I am…physical stuff.*

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[54] In Cree: grandmothers

She led the conversation into the direction that I expected. Both her mom and step-dad were products of the residential school system and I think Nicki might have talked more about her present issue of physical abuse if the popular theatre practitioner had not told her that “you don’t have to say it all.” I think she took that as a cue to stop. Nevertheless, it was part of the critical action research process where the goal is to “increase the closeness between the actual problems encountered and the theory used to explain and resolve the problem” (Holter et al., 1993; Masters, 1995). In part, we did achieve the closeness of the problems to the theory but we did not resolve the problem of physical abuse. I am not sure that we could have done anything but support her in her decisions to stay or leave the relationship. The second goal of the critical action research process is to raise the collective consciousness (Holter et al., 1993; Masters, 1995). In this instance, it was initiated by Nicki and reinforced by me.

As the researcher of this project, I felt a responsibility to share my personal history so as not to feel or appear like a vulture preying on their stories and pain and also to raise the collective consciousness of the after-effects of the residential school experience on Indigenous sexuality, nudity, and awareness. I also shared a story but I choose not to write about it here, as I do not have the anonymity of a pseudonym to protect myself. The personal story was an example of the lived experience of multigenerational trauma that supports Nicki’s story. We stood together as Indigenous women who have shared some similar backgrounds and slowly the younger women in our core group began to speak up.

Willow, a lesbian within our group, demonstrated that the young people also have stories to tell. Her major comment was about her own experience in learning about the differences between men and women, through her family, older men, and her mother. She coyly said:

> *When did I learn what a woman was? I learned what a woman was when I was taking a bath with my cousins. (She laughs). I remember taking a bath with my cousin and whatever. I remember when I was a very young girl I remember, that girls were different from boys and I never actually got taught by my mom the difference between boys from girls.*

Her tone became more serious and she added:

> *Then, I learned what the other sex was by being abused by a man, by an older guy, so that's how I learned what a man was… I was kind of lost and alone about my sexuality. I was really happy that when I did come out, that my mom and dad were accepting. I thought that they were going to reject me but they didn't.*

When Willow decided to tell people that she was a lesbian, she feared that she would not be accepted by her mom and step-dad. It would have been more alienating for her to feel rejected for being a lesbian when she already had this abusive experience with a man. She would have been even more marginalized. Her courageous effort to talk openly about all of this demonstrated that the process of critical reflection was happening naturally. Once again, the distance lessened between the subject and problem as she explained what had happened. The latter part might have involved confronting her abuser but at least she was disclosing this experience. This was an important step as we were in our first week of the popular theatre and action research process.

During this first week, I was shown that our group members have been subjected to alcohol misuse, family violence and sexual abuse. The response to a simple question like how did you become aware of the difference between a woman and man, the stories of victimization and witnessing victimization, were not surprising to the researcher. When Nicki spoke about seeing family violence happen between her stepfather and mother, she acknowledged that it was not normal, and this is not normal from a cultural perspective. As illustrated by Nicki's story, family violence has become a multigenerational cycle. The last time I spoke to her, she said that the violence is no longer happening and the reasons for that are not known. Although Willow spoke about being a lesbian and having been sexually abused by a man, she later mentioned that she sometimes feels attracted to men but then talks herself out of it. When I shared my story, I helped to demonstrate that there are multigenerational effects that reach back to the residential school era. The popular theatre practitioner's journal stated that the images of men were, "all brutes, bastard and the absent." There seemed to be no positive male energy or figure anywhere, "not even a Moshum." Although the absence of male energy might seem that the group was bashing men, it was not intended.

Although the aim of this work was to create stories and develop a play on STI/HIV prevention for the community, issues like family violence, sexual abuse, and alcohol misuse surfaced. The group was identifying issues with honesty, the value associated with the southern door of the Indigenous Iterative Webbed Circle. It was also part of the action research reconnaissance phase as we gathered information for STI/HIV prevention using the experiences and feelings of the group. Furthermore, had we not been practicing the value of kindness we would not have been able to discuss these topics. These abusive experiences eventually became fictionalized as general themes within the story of the heterosexual transmission of sexually transmitted infections including the virus that causes AIDS.

In their journals, the co-researchers wrote about their discussion on gender, nudity, and sexual awareness. All the respondents were positive about the talking circle because they enjoyed sharing, listening, and being part of a group. One person wrote:

> *Today was so awesome, good day in school, good day in "group" that's what I call our meetings. I was so outgoing, and so comfortable with myself today, I love it. This group is grounding me and bringing my head out of the clouds…I've come a far way, and am proud of my progress, all I can do is move forward. - Leila*

Our first week together was powerful as we explored sensitive topics but it was also empowering to belong to a group. The value of kindness was helping to build morale amongst group members as we were building trust, opening up, and getting to know one another. Our creative process would not always be as easy because the attendance became sporadic.

Poor attendance was a cautionary flashing light to the researcher and popular theatre practitioner. We were still trying to develop as a group and while we tried to forge ahead to identify the issues around STI/HIV prevention and finding ways to express it, we found the absence of our group members holding us back.

On our first Sunday together, one of our goals was to understand better the lived experience of being HIV positive, so those of us who were in attendance watched two videos featuring Ken Ward, the first Cree man to identify himself as HIV positive. The videos were "The Long Walk" and "I Will Not

Cry Alone." Afterwards, the group began to do some brainstorming and created lists of words that came to mind when they heard the word "sex," and "STI/HIV/AIDS," and "barriers to condom use."

In our talking circle that Sunday, I tried to build the morale of the group by talking about the heroic effort that this action research and popular theatre project required. Since the group members had already began to disclose how they came to learn about the difference between a woman and man and because those stories that were shared during the week were about violence, the popular theatre practitioner and I were realizing that the stories were of a sensitive nature. Jane and I discussed our concerns about the nature of disclosing stories about sexuality with the group. I wanted to be sure that everyone was feeling emotionally safe and yet I was afraid that they might feel vulnerable, exposed, and perhaps judged. Our talking circle was about making sure they felt supported and safe. Eventually I concluded that I was spending too much time worrying and wasting my energy. These were young people who were willing to take a stand and deliver a message about STI/HIV. We discussed my concerns:

Doug: What was it exactly that you are afraid of?

Josie: We're talking about a lot of sensitive stuff and to me it is sensitive talking about any kind of abuse…I would wonder [if] you guys [are] okay? So that's what I am worried about. I want you guys to feel comfortable and safe and so maybe that's just the mother in me but that's the way I am.

Jane: I think there is some old unburied [issue]. People are struggling a lot with that. It is very powerful and theatre is very powerful and once you start to do that, then you make yourself very vulnerable in the process. You expose yourself. I am just stunned that people want to do that. I wonder if I have enough hands here to catch you guys.

Josie: How are you guys coping with that? That's what I am wondering about. That is why it is important during this talking time that we share anything and feel safe enough and trust in the group to talk about your feelings or thoughts or whatever, that's what I've been keeping in my heart. That's what I want to say.

Nicki, who supported the group in her capacity as a mental health therapist, emphasized the importance of talking with people you can trust, like friends. The meetings were important to the group. One group member stated:

> *Doug: I am always glad to show up and always be here every time. I look forward to the exercises that we are going to do. Just being here is great. After I go home and after I spend time here, I go home having a good feeling inside of me, just being a part of this. It is something to show to the community. I know it is going to give me something back, like even right now I feel good just being here how many days now. It makes me feel good inside and if I do feel sad, I understand that you guys are here for me too. I already know that. It is good. It's just nice to also listen.*
>
> *Jane: I am glad to be in the circle even though it is small today. Josie and I talked a little bit about being scared because we're not therapists and we're asking people to tell the truth about themselves. And the thing is when you ask people to tell the truth about themselves, many of them do! (lol). What do you do with the truth?*

While the young women were away that Sunday, the two young men in our group, Rocky and Doug, talked about their overall awareness of STI/HIV and what they would like to include as part of scene development, community representation, and stigmatization. This was productive and insightful. We had a misogynistic conversation about "crack whores," who are generally women who sell their body for the drug, "crack." It is a very demoralizing term to describe female drug addiction and the undesirable lifestyle factors that can lead to STI/HIV. Further to the illicit drug use, the young men identified prescription drug misuse.

> *Rocky: You can get 40 T3s in one shot and you can go pawn them off for joints or whatever you want.*
>
> *Doug: Two bucks a pop.*
>
> *Rocky: They are as good as money, T3s, T4s.*

Using the health care system to support an addiction coupled with the selling of illegal drugs factors into the spread of STI/HIV. Listening to this brief discussion between the two young men, the popular theatre practitioner guided the conversation back to telling stories that are representative of the population because not all Indigenous people use drugs to engage in sexual activity. The young men were telling us these stories to consider for the play even though not all the group members were there.

Are stories that depict Native people as alcoholic and addicted to drugs representative of the entire population? There would be people who would disagree with that portrayal of Indigenous communities but from Rocky's perspective people giving their bodies for street drugs or selling prescription drugs for money is a reality. It is a reality that Aboriginal people who have faced discriminatory stereotyping might not feel comfortable with for many reasons.

STI/HIV prevention forces researchers and those who are interested in working in this area to look at the driving forces causing STI/HIV transmission in populations that are marginalized or separated and segregated. In part, STI/HIV prevention must address poverty and addictions because those are determinants affecting the sexual health of this population. Prescription drug misuse did not factor into the creation of "My People's Blood," but in "The Alix Story," there was a scene on crack addiction, and the resulting child neglect, and child sexual abuse, if left unhealed, results in unhealthy lifestyle choices that lead to the adult transmission of HIV.

Stigma of STI/HIV

As our Sunday progressed, we continued to discuss story ideas around STI/HIV prevention with Rocky, Doug, and Nicki. This led to discussing the stigma that is based on fear of becoming infected with STI/HIV. This conversation began with Rocky making a suggestion about a story that he thought was representative of the community. He suggested the following:

> *Rocky: We can do that drunken Native scene where there are leftovers at the party and then there's a guy getting mad at the women there, and there are a couple of women getting beat up by one guy and there's an old woman trying to stop it. I've seen a couple of those parties, AHHSTEH!*

The violence against women that Rocky has witnessed at parties prompted some thought on what type of story to tell. The factor of alcohol and drug use leading to the spread of STI/HIV was certainly important but just how we linked it to the transmission of STI/HIV needed to be made clear so we encouraged the sharing of many stories and ideas for scenes during this stage of the process.

Jane: We've got lots of choices to make. Lots of time…

Josie: …As a group we'll discuss what we want to present too.

Jane: We might create 30 stories and choose the ones that are most important.

Nicki: What about the one Ken was talking about.

Rocky: When he was saying, "What a weird disease this it, it makes you sing and then weeks later while having cereal, the guy is being hauled out in a body bag."

Since the young women in the project were not in attendance, it was difficult to make a decision as to what story to tell. While ideas were coming forward, we had to wait. At least, we were making some progress. I took the opportunity to discuss the idea of sex being considered sacred.

Josie: Jane and I had a talk about STD's and HIV and how sex is about creating life. Sex, in part, is about the life giving force between a man and women, now STDs and HIV are a part of it. The bacteria can be treated with medicine but these viruses they stay with you for life and so those viruses become a teacher for you to help other people.

If we consider that sex is sacred and that the most intimate part of ourselves should be respected in a loving way with our partner then perhaps STI/HIV can be prevented. However, this is not always a realistic possibility. All it takes is one error in judgment and the outcome could affect your entire life. Some people learn from their mistakes and others do not. Some people have the will to teach other people through their life lessons and those people can make a difference in the lives of these other people. Being open and honest about your life history takes a tremendous amount of courage as does dealing with the stigma and judgment that some people might put on you. Rocky then asked the following question:

Rocky: Would you tell somebody that you had STDs or AIDS?

Josie: Yes. There's something about boundaries in any work that you do and get involved in, and even in relationships you have to get to know the person to build trust and be able to confide.

Rocky: I would be really scared and I would run away and I would think about hurting myself probably if I caught something like that. I wouldn't want to hand it over. I wouldn't be able to do that. It would be pretty hard though.

> *Josie: It can be but it's not the end of the world when you think of it, everybody is going to get some [disease or injury] in their life and that's a part of life. When a baby is born and has HIV, the baby has HIV. If a person lives to be 50 years of age and they have diabetes, they get diabetes. A person could have their leg amputated after being in a car accident. STDs and HIV are other diseases and there are some things that may be far worse than HIV if you can imagine it. What do you think would be worse than having HIV?*
>
> *Doug: Ebola.*
>
> *Jane: It's a virus where you bleed from your eyes, your nose, your mouth, your stomach, and your skin. There's no cure for it.*
>
> *Josie:…There tends to be a lot of blaming on people who pass STI/HIV. The stigma hurts your self-esteem. People are so hurt they might even kill themselves, they're so hurt. People judge and I think that it takes a lot of courage to say, "I've got HIV," or something like that. When Ken Ward was talking about this community needing a hero, it needs more than a hero, it needs a heroic effort, and together we can be a part of that. I am hoping we can do that.*

There are probably many people like Rocky who would be so afraid of getting an STI/HIV that they would run away and maybe attempt suicide. Our conversation on story ideas led us to talking about the stigma associated with STI/HIV. This presented an opportunity for me to try and dispel some of that fear by discussing other illnesses, injuries, and diseases that people cope with across their lifespan.

This important discussion eventually became part of the story that was developed in the "Buddy and Savannah Story" in the play "My People's Blood." Rocky's character, Buddy, discloses to his girlfriend that he has HIV and he informs her that she should get tested, too. When creating the play, the group members decided to emphasize the stigma that contributes to and results in Buddy's death. Does HIV kill Buddy or does the stigma? In this story, it is the stigma and rejection that prompts the alcohol related fatal crash that eventually results in Buddy's death. Our hero becomes a tragic hero. This will be discussed in greater detail in Chapter Seven.

Stigmatization is debilitating to the mind, body, spirit, and emotions. While it is true that STI/HIV can be prevented, and ultimately, it is the responsibility of the person to practice safe sex, there are many factors that contribute to the spread of STI/HIV. Across the nation, there are individuals and families living within communities who still find it difficult to disclose they have a disease. The shame is difficult to bare. It is easier to blame a person and shame them rather than accept them for who they are. While being sexually intimate is a personal choice, contracting an incurable disease impacts families, communities, and communities across the nation. Without condoms, the diseases spread and no one is immune. In this project, we became aware of the need for community members to become more aware of how stigmatization can contribute to the transmission of STI/HIV. If the character, Buddy, had felt too ashamed to disclose his condition, he might have spread the disease further.

The following Monday, the popular theatre practitioner worked on developing the acting skills of the participants and began the social planning and issue identification phases. The popular theatre practitioner carried on with the warm up and skill building work because the young women were back and we had a new female group member named Diane.[55] The group practiced putting sound and movement together. Jane had the co-researchers/actors portray characters. These types of exercises helped participants to develop and portray characters other than themselves. The concentration was weak.

The popular theatre practitioner then moved into the social planning phase and issue identification phases by asking the group to identify issues and barriers. We reviewed and added to the lists.

In brainstorming sessions the group made new lists to identify the barriers to safer sex, barriers to abstinence, and barriers to monogamy (See Appendix D). The co-researchers/actors were also asked why some individuals have a lot of sexual partners. All group members generated answers based on what they thought were appropriate responses for men and for women (See Appendix E). Identifying barriers to safe

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[55] Diane was a mother who joined the group because she was interested in HIV prevention.

sex, abstinence, monogamy and reasons for sexually promiscuous behaviour required honest reflection, a value associated with the southern door of the Indigenous Iterative Webbed Circle.

The group also discussed the meaning of abstinence. The popular theatre practitioner asked the co-researchers to place sexual activity on a horizontal line. At the far left of the line was ‘looking at each other’; at the far right ‘sexual intercourse’. As they named different sexual activities, the popular theatre practitioner asked them to place these activities on the line. They identified from left to right: looking at each other, getting to know one another, holding hands, hugging, kissing, ear nibbling, touching with clothes on, rubbing with clothes on, touching with clothes off, fingering, hand jobs, oral sex, 69, and then sexual intercourse. Co-researchers were then asked to imagine drawing a vertical line (privately) for themselves that represented their personal boundary, a line they would not cross. The facilitator referred to Planned Parenthood’s definition of abstinence as any sexual activity up to but excluding sexual intercourse, a penis penetrating a vagina. Although the Planned Parenthood definition would prevent pregnancy, this definition of abstinence would not necessarily prevent contracting STI/HIV.

The Monday session was productive. We were making progress in identifying the factors to preventing STI/HIV. The facilitator encouraged the group to be vigilant about their attendance. She wanted the participants to know that in order to move forward as a group, everyone’s attendance was important and when attendance falls short, the plan changes according to where the group finished. Her role was to help move the group forward. After her long lecture there was a moment of undecipherable mumbling among the group members. It took a moment for the group to absorb what she said and find their voice. As the researcher, I reiterated the importance of not having just one hero but a group of people putting a heroic effort forward for STI/HIV prevention while being respectful in the group. I was also mindful of sharing power and I asked them to think about how we could get more community members and elders involved in HIV prevention. As I spoke, the group absorbed what the popular theatre practitioner had said but not all of them spoke. Rocky and Willow remained silent. Then one by one, some of them started talking about their attendance and energy levels.

> *Leila: I doubted coming today because I felt like whatever we talk about, I get too emotional. I think that was why I was crabby on the weekend. I thought too much about everything. I realize that I don't have to over analyze everything…*
>
> *Jane: We're glad you came.*
>
> *Jasmine: Today was okay other than some parts I stayed out of but that was because I was too shy. Other than that hopefully I can start feeling more into it like not too shy, I guess but I'm glad. I'm happy that I came and I will see everybody tomorrow.*
>
> *Doug: Today I was tired all day I didn't get too much sleep yesterday. I am still looking forward to coming here. I was looking forward to seeing the people that weren't here yesterday. In a way I just thought of you guys even through the weekend, just thinking…Coming here and not knowing too many of you I am being totally open with myself.*

The group decided that meeting on Sundays was not possible because some group members wanted their weekends to themselves. The original schedule had been developed based on availability of the co-researchers. After showing them the schedule we had come up with, they had agreed to it but in reality they wanted their Sundays off. This was the first power sharing compromise and the group agreed to work every other Sunday because we still needed the time to do the drama. After revising the schedule, I thought we all hoped that the attendance would be good. Although changing the schedule helped the situation, it did not alleviate the attendance issue entirely. Some thought of quitting the project, one mentioned having a mental illness, others wanted to be with their friends, one was shy and another was simply tired. I hoped that these issues would be partly alleviated by providing food, juice, and water to keep up the energy levels of the group members before we would lose them. Since they were coming to the project from work or school, their busy schedules did not give them time to eat. Providing nourishment encouraged their attendance.

Spinning Silk; Moving to Script Creation and Scene Development.

The following section describes the script creation of the play, "My People's Blood." Three stories were created, "Kehew and Pisim," "Savannah and Buddy," and "Alix's Story." The group was asked to create a graffiti wall: two were created. When the core group began to devise characters, three stories emerged. The individual characters that were created were also part of families and the family characters were also drawn on long rolls of paper. Using the graffiti wall, and the popular theatre practitioner's notes of script creation and character role development, I set script creation in the context of the Indigenous Iterative Webbed Circle.

Spider Woman's spinneret glands have produced the silken thread and as she produces the sticky cotton candy variety she waits patiently for a breeze to blow and then she releases the thread hoping it will catch onto the red willow. It does. In our process, the rolls of paper are the first thread that is cast across by Spider Woman. The core group members chose their colours then scrawled drawings and words, slowly, quietly, and carefully.

The process of drawing characters did not just happen. It began with the creation of a graffiti wall to encourage the core group members to express and write their thoughts about STI/HIV. This allowed the group members to collectively and quietly respond to one another's thought with a comment or question to evoke further responses. It was like being allowed to write notes with your whole class after watching videos, listening to one another, and listening to the elders, the nurse, the popular theatre practitioner and me, talk about STI/HIV and health-in-general from social, psychological, biomedical, historical, and cultural perspectives. The graffiti dialogue allowed the group to show one another their thoughts on paper.

Group members either drew revealing pictures or wrote cryptic comments in clusters about what they or other people thought about STI/HIV. Like graffiti elsewhere, it allows readers to interpret the words (See Appendix F). A second graffiti wall was created regarding the undesirable consequences of AIDS. More negative than positive images were composed (See Appendix G).

The graffiti wall exercise encouraged the group members to create critical images and respond to those images. This led to the scene development process whereby the group continued drawing to create characters. They explored a wide variety of male and female characters of different ages and they explored the role of pets and other symbols. The group then chose a few characters to develop and drew the characters’ lives. In some cases, dialogue was added to the drawings. Part of the story creation identified where and how HIV/AIDS entered the character’s life; either they contracted it or someone they knew contracted the disease.

Once key moments were drawn, the group improvised scenes from the character’s story. Those improvisations were recorded, transcribed, and presented back to the group. In each case, every effort was made to transcribe as exactly as possible. As is common with this method, some group members were surprised and dismayed by the way their improvisations read on the page. They revised their scripts, which were then retyped and copied, until they were satisfied with the text. The group then began rehearsal, staging of the scenes, and learning of lines. During rehearsal, lines continued to be edited and changed.

To a large extent, the decision about what would be performed was made practically, based on who showed up for rehearsal. In the collective creation process, roles and scenes tend to ‘belong’ to the actor(s) who created them. If the actor who creates a role or scene does not attend rehearsal, the scene cannot be rehearsed or developed. Actors/participants sometimes chose to pursue some scene ideas and not others for reasons that were not always clear to the popular theatre practitioner or researcher.

Of the three stories that were created as part of the play, Alix’s story was the only one developed using cartoons as a starting point for character development. Initiation of the Savannah and Buddy story happened when Rocky chose Buddy, a character developed in the Alix Story. The core group members then developed the Savannah and Buddy story. The Kehew and Pisim story was developed from a discussion between the popular theatre practitioner and co-researcher/actors. In all three stories, a narrative line was developed.

Alix’s friends, then family, were created (See Appendix H and I). Two of the female characters in this story have been sexually abused or inappropriately touched and all of the characters use drugs. The characters form a backdrop to Alix’s social environment where using alcohol and drugs are the norm. Alix’s family has been through one struggle after another. The characters are so far removed from mainstream reality that they seem almost unbelievable. These are the characters that the core group members initially developed but as the story continued to be developed, the names changed and characters disappeared due to a shortage of actors. Some experiences contained in Alix's story remained true to the original character. Despite experiencing childhood sexual abuse, alcohol and drug misuse resulting in unwanted sex that leads to her HIV positive status, Alix becomes a community advocate for STI/HIV prevention.

As stated earlier, Rocky chose to revive the character Buddy from the Alix Story and use it. The popular theatre practitioner worked with the core group members and they developed a story line around Buddy's infection with HIV as part of the Savannah and Buddy Story in, "My People's Blood." After improvising the story and tape-recording the dialogue, the popular theatre practitioner transcribed the tape brought the hard copy to the group for editing and final approval.

The Kehew and Pisim scene was not developed like the Alix Story, with characters drawn on long rolls of paper. It was developed through a discussion. Leila thought they could develop a story about an aggressive girl with low self-esteem who wanted to have sex but did not see the need to use condoms. The story is about a young female who wants to have unprotected sex and a young male who wants to use condoms. Doug had a lot of very clear ideas about this couple and what happened to them before their argument in the scene where she wants sex and he does not. Doug and Leila worked under the guidance of the popular theatre practitioner. With her guidance the co-researcher/actors improvised scenes and afterwards she transcribed pages of notes, brought them to the co-researcher/actors for approval and then edited the scripts. The scene was performed for the elders but not for the community audience, as the two original group members who created this scene dropped out of the group near the end of the process. The story that was never performed for the community audience was about making lifestyle changes and a young couple agreeing to monogamy after infidelity.

It was not clear why the original actors opted out. Their journals indicated they were increasing their self-esteem and being involved was empowering as it was helping to develop their capacity and confidence. Prior to dropping out Leila wrote in her journal how attending regularly benefited her personally by building her confidence:

> *Oh thank God for this group! I don't know where I'd be if I weren't here. Oh wait, yes I would be drinking, wasting my money, losing my license or something dumb. This group is so uplifting, giving me happiness, and leaving me feeling like I've achieved something. I am back to loving life. I live for myself, for once. I'm graduating so I get to dress up and make my grandparents proud. My boyfriend is coming back to me so I haven't completely lost him. Today when I had to be a character in a picture, I had to hug Darcy and "straddle" him. I wasn't nervous or shy at all. I actually felt comfortable. I'm looking forward to more similar scenes. All I had to think of was me, and the person I love to get in character, it worked. Group all in all was beautiful.*

In his journal Doug wrote:

> *Today was amazing…Last week was our sweat and I'm still feeling good about it. I took Friday off but my boss told one of the workers that they were worthless and that person walked out on him so I went and spent that weekend with that person (hint! hint!). I was still angry with him today but I just let it go but he had no right to say that and I'll never forget that. Yesterday was fun but I was a bit out of it, tired, confused, but never forget how to be I really liked the Inuit hand games. And then I went home and really relaxed and woke up feeling a lot better, less stressed. After work I was looking forward to being here on time and I did it. I'm happy about all the things we talked about, did today. I loved the names, the acting, Leila's great! I've always liked to be in drama, so this works out really great for me, I love not being me, because I'm to weird, I need to let it out somehow, someway.*

The project seems to have had an uplifting effect on their morale. Although Doug had to deal with work related issues in his life, he looked forward to being on time and participating in the group process that involved attending the sweatlodge.

When Doug and Leila performed their scene for the elders, we introduced the scene as "Kehew and Pisim," and someone mumbled something in Cree and then there was a giggle and suddenly they were all laughing or smiling. Someone had thought they heard the derogatory Cree word "Teesim," which is a woman's vagina. Because the story contains scenes of sexual playfulness where Pisim, the female character, straddles Kehew, the male character, the play on words was inappropriately funny because it stigmatizes the Indigenous female just as English swear words stigmatize English speaking women. Pisim, which means Sun in Cree, is beautiful, masculine, and powerful, yet Pisim was mistaken for Teesim which implies promiscuity. Perhaps the fear of being laughed at was the determining factor for opting out. Perhaps the conflict that happened in the group over attendance issues and power sharing turned them away. Perhaps the reason was the stress of dealing with STI/HIV testing and prevention, in a community laden with stigma. Maybe they had better things to do with their summer. There are so many possible reasons why they dropped out but I never asked them out of respect for their decision to withdraw at anytime without a reason.

After the laughter subsided and the elders watched all three scenes, Jane noticed that the elders seemed to be more interested in scenes they could relate to. In "Alix's Story," Alix tells her Kokum that she has the virus that leads to AIDS and the elders were interested in how the Kokum would react. Would she be upset? Would she get mad? Would she ask questions? Unfortunately, this scene was not performed in the final production because nobody wanted to play a kokum character. The group members felt uncomfortable not knowing the Cree language well enough to speak it and they did not want to offend anyone by making up gibberish and none of the young men in the group wanted to play a kokum. One of the ideas that Jane eventually posed to the group was to have one of the elders play this role but the group members decided that it would be too difficult and scratched the scene out. The only scene that had an older character was the "Savannah and Buddy" story in which Buddy tells his mom he has HIV.

Using Spider Woman's silken spider weave enabled me to connect the individual stories of violence and sexual identity to the effects of multi-generational trauma within families stemming from the residential schools. It became clear that the barriers to safer sex involved feelings of denial, shame, low-self esteem, judgement, along with addictions and communication problems. Some of the group members disclosed unhealed sexual abuse issues and addictions. Today the stigma of HIV/AIDS demands that people address these kinds of issues to develop self-esteem and healthy sexual practices. Using the Indigenous Iterative Webbed Circle allowed me to examine sexuality and the need for STI/HIV prevention at the levels of the individual, family, community, and nation. It helped me to identify the need for STI/HIV prevention across the nation including elders. It allowed me to connect the contemporary struggles to being human and sexual in an Indigenous community that has higher rates of STI/HIV.

Although the origins of the dream catcher are laden in myth, a myth is considered a tool for human use. By using a mythological symbol I was helped, as a Cree person to identify with the mythology of other tribes, thereby allowing me to self-identify and speak across the cultural divide. The use of the dream catcher stemmed from the idea of weaving stories together in a collective creation. Spider Woman who spins webs is considered a “true creatrix for she is thought itself,” (Gunn Allen, 1986, p. 14). In the creation of this STI/HIV prevention play, story development began with thought itself.

Even though we, as Indigenous people, are surviving despite life-threatening diseases, the stories do become historical and tribal as we relate to the context of intergenerational trauma due to colonization. Our discussions on the difference between man and woman roused some traumatic stories, stories impacted by colonization and a multigenerational cycle of abuse. The stories were highly sensitive in nature. Child sexual abuse figured prominently in the backgrounds of character development leading to the transmission of STI/HIV via alcohol and drug misuse. This lifestyle coupled with women’s drug addiction led to the idea of contracting STI/HIV and the stigma associated with that. Colonization has impacted the sexuality of Indigenous people, particularly the women.

Indigenous people have to confront the stereotypes surrounding sexuality and prevent STI/HIV. Although STI/HIV can be curtailed using abstinence and a cultural program, there are other choices to prevention.

Developing stories on a highly sensitive topic required commitment to the cause and to the group. Attendance sometimes fell short but three stories were developed. In the end we had one story about stigmatization, another about advocacy, and the third about addressing addictions and pursuing monogamy. The popular theatre practitioner used some of many methods to assist the group to find representative stories to character development. Individuals, families, communities, and the nation are impacted by STI/HIV and, in this project we created three stories reflecting this as part of the play, “My People’s Blood.”

Chapter Seven: An Analysis of the Play

"My People's Blood"

The purpose of this section is to provide an analysis of the play "My Peoples' Blood," in order to comment on the community response. The methods to analyze the plays are explained, followed by a description of each story plot. Following that, I relate the play to the Indigenous Iterative Webbed Circle, a table of themes for each story, and discuss ion of similarities and differences and the effect the stories had on the community.

The plots are presented and the stories analyzed within the context of the determinants of health and connected to the Indigenous Iterative Webbed Circle. The three stories addressed some of the positive and negative impacts of income and social status, social support networks, education and literacy, employment/working conditions, social environments, physical environments, personal health practices and coping skills, healthy child development, biology and genetic endowment, health services, gender, and culture. From a, *determinants of health*[56] perspective, some determinants were emphasized, and not all determinants were addressed and some were merely touched on. It is not to say that the message was incomplete, as it was not the intention to address every determinant to STI/HIV prevention, but to create stories that the community members could relate to -- and they did. Popular theatre and action research offer "health warriors" the opportunity to whoop it up and create social/health change for the greater good (Cardinal et al., 2004, p. 60).

The performance had been advertised on the local radio and the group members were encouraging the community to attend. On that summer evening elders, leaders, health care professionals, my co-supervisor, supportive family members and interested community members attended the performance at the school gym. The community members were enthusiastic participants in a post-theatre discussion. Each story in the play was approximately twenty minutes in duration. Over two hundred community members gave their reactions to the play and provided possible interventions to prevent

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[56] Auger and Letendre (2007), stress the importance of considering the determinants of health from the cultural lens of Aboriginal peoples.

someone from becoming infected with STI/HIV. No formal interviews were conducted with the audience members. They addressed the difficulties parents face in providing sexual health education and the need to address the social stigma of STI/HIV and provide a social support network for people who have HIV. Despite the success we had in presenting this information via the use of drama, the community acknowledged that the stigma of STI/HIV is still crippling the prevention effort. Lastly, community members felt that popular theatre is an appropriate tool for addressing all youth issues.

Plot for the Three Stories in "My People's Blood"

Kehew and Pisim, is a love story about a relationship between a young Indigenous male/female couple who struggle to maintain a monogamous relationship in an environment where the norm is drinking and one-night stands. On their anniversary of their first year together, Kehew[57] and Pisim[58] are spending an evening at the beach. Pisim has brought a case of beer to celebrate the occasion with her boyfriend, Kehew. Her boyfriend does not want to drink the beer she brought as he is in a quiet and reflective mood. To mark the special occasion, Kehew gives Pisim an expensive necklace to honour their one-year anniversary together. She adores her necklace and the thoughtful boyfriend who gave it to her. Wanting to establish some form of intimacy with him, Pisim tries to get Kehew to drink, swim, and even make love at the beach but he chooses not to, especially without a condom. Even though they have been together for over one year and she is on the birth control pill, warning bells of infidelity go off for her. She does not see the reason for using a condom unless he has been sexually intimate with someone else and not using a condom. After having finished all of the beer, Pisim starts to think of the worst-case scenarios and then storms off without Kehew to a party.

Later, Kehew and Pisim are at the same party. As at typical parties, people are there to have a good time which for them involves drinks and flirtation. Atim[59] has circled around Pisim and he decides to mark his territory for the night while the beautiful Star makes her moves on a lonely Kehew. Pisim sees

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[57] In Cree: eagle
[58] Sun
[59] Dog

Kehew with Star and in a moment of jealousy Pisim comes close to having a physical confrontation with Star but Kehew intervenes.

A week passes and finally Kehew calls Pisim and he tells her the reason why he insists on using condoms. Kehew admits to having had a one-night stand in Edmonton, eight months ago. He had unprotected sex with a female that he did not know. This incident had happened after a major argument with Pisim. After getting back together with Pisim, Kehew did not want to risk giving Pisim an STI or HIV so Kehew insisted on using condoms. He also had been tested for HIV during the week that they were not speaking to one another and he found out that he was HIV negative. After listening to Kehew, Pisim confesses to an error of judgment.

Pisim's problem is that when she is intoxicated she loses control of her inhibitions. Like salt on an open wound, Kehew listens to his girlfriend tell him that she got drunk and woke up naked with a guy, named Brian. The sexual incident happened because she lost control of her body while under the influence of alcohol. The sordid confession offers some relief in that she tells Kehew that she had tested for HIV and her results were negative, too.

Despite the confessions of infidelity, the couple decides to work things out but they realize that their problem is alcohol consumption. This story of their quest for monogamy provides hope for two young Indigenous people who despite the challenges in their social environment, choose to use their own personal coping skills to stay HIV negative and they both decide to quit drinking.

Traditionally, Cree people do not consume alcohol or drugs. Traditional Cree people blend their cultural identity with their gender roles to form lasting family relationships. Many parents want the best for their children and they hope their young people will know who they are as Indigenous people and be able to form a lasting monogamous relationship with someone they love, in the era of AIDS.

By using the determinants of health perspective, I examined what factors were considered in the play's stories. Although health care professionals are familiar with the determinants of health, population health concepts are part of an imposed language that requires training among Indigenous people in Aboriginal communities (First Nations and Inuit Health Branch – Health Canada, 2007). "Determinants of health" are an unfamiliar concept that might seem mysterious, much like a spider web (First Nations and Inuit Health Branch – Health Canada, 2007).

According to the Public Health Agency of Canada, gender refers to the array of society-determined roles, personality traits, attitudes, behaviours, values, relative power and influence that society ascribes to the two sexes on a differential basis (http://www.phac-aspc.gc.ca). In the Kehew and Pisim story, Pisim has a very low self-concept. She refers to going out with friends and drinking as "being a bitch." She knows better but chooses to leave Kehew on their anniversary of their first year together as a couple because he does not want to be sexually intimate. Instead she goes out drinking. She does not know that the reason he does not want to be sexually intimate, at least without a condom, is because he has had an affair. It is Kehew's initiation of honesty about his infidelity that prompts Pisim's crushing news about her own infidelity and leads to a discussion of the effect of alcohol on their relationship. The story alludes to available health services through which both parties test negative for HIV. Afterwards, the couple realizes they both have the coping skills to manifest a relationship based on monogamy and are willing to abstain from alcohol to cope with their social environment and the risk of HIV in their physical environment.

The Kehew and Pisim story mirrors events in many Indigenous communities across the nation. It presents the difficulties that individuals, families, and communities have in addressing STI/HIV prevention in an environment where alcohol and drugs are used. This play presents issues and topics that are taboo. The community members know that these problems exist but do not normally present this information in an open forum. The protective fiction of theatre allowed this taboo material to come out into the open. The play is a cautionary tale of how infidelity and unprotected sex can lead to STI/HIV. The characters are stereotypes but present an urgent social and health issue related to drug and alcohol consumption. It portrays Indigenous women in a derogatory light. Had the play been performed, it would have allowed the community members to discuss the stereotypes and ways to transform gender roles to improve the social environment and thereby alter the negative psychological image. The individuals who created the play developed it with the intent to create social/health change. This project speaks to the need for culturally-based primary prevention addressing gender roles and developing personal health practices and coping skills for STI/HIV prevention. I suggest health care service providers develop public health approaches to support rites of passage ceremonies in Indigenous communities. These concepts will be expanded on in Chapter Nine.

Savannah and Buddy is a paradoxical story about young Indigenous people who are not living according to any traditional Cree values; instead they live a sexually risky lifestyle. Savannah and Buddy's lifestyle involves drinking alcohol and cavorting with the opposite sex in the pursuit of a one-night stand or a relationship. The scene starts out at the local gym, a place where a young attractive man such as Buddy can talk to an available female such as Savannah. In childhood, Savannah and Buddy were close friends. As they got older their friendship turned into a sexual relationship without commitment. Buddy admits his love for Savannah but she will not admit her love for him because he has only said those precious words when he was drunk, demeaning the word 'love.' Their relationship is confused, with fatal consequences. Rather than communicate their feelings and work out their relationship, they seek other people for intimacy and sex.

The turning point occurs when Buddy tells Savannah he has HIV. Not expecting rejection from Savannah, he is upset and surprised when she kicks him out of her house and life. He turns to his friends and mother. Friends and family reject him, leaving him to deal alone with the consequences of having the virus that causes AIDS. He turns once again to Savannah but again she pushes him away as she tries to deal with her own fears of having HIV. Rejected, Buddy warns Savannah that she will regret pushing him away. He consoles himself by turning to the bottle. In a fatal turn of events, Buddy crashes his car and dies while drinking and driving.

The audience members do not know if Buddy's death is caused by his intentions or not. Whether it was deliberate suicide or an accidental fatal crash, his friends and mother stand at his grave and there we see Savannah admitting her love for Buddy. The story is not over. After testing for HIV, Savannah is relieved to find out she does not have the deadly virus but as she walks out of the doctor's office two young women are gossiping about her. The scorned Savannah confronts them, much to the humour of the audience.

In her narrative to the audience, Buddy's mom reflects on the mistakes she has made as a single parent. She realizes that she did not have the skills or knowledge to deal with her son's disease. In her remorse, she points fingers at the young people and older people who are cheating on their spouses. She points out that HIV does not know boundaries. In her remorse and bitterness, she also states how difficult it is to raise a son as a single mother and draws attention to the absent fathers in the community. Having raised the issue, she states that it is the father's role to talk to his son about safe sex and relationships. Rather than giving in entirely to tragedy, after Buddy's death, Alice, his mother, decides to learn more about HIV from the local nurse and becomes an advocate for AIDS awareness. Alice wants to start a talking circle for parents who are concerned about the sexual health and safety of their young people.

In the story, Buddy tries to find positive social support through his friends and mother, but what happens when he discloses having HIV is not what he hoped for, as noted in the script of , "My People's Blood":

> BUDDY: 'S kinda serious. *(pause)* I don't know if I… I don't know how to tell you this but…
>
> SAVANNAH: But what? Come on Buddy, you can tell me anything. Remember that time in grade 8 when you were working canteen and you stole all that money? I took the blame for you. You know how much I care for you.
>
> BUDDY: I have…I'm…I'm H-H-H-IV positive.
>
> SAVANNAH: You're HIV positive? When did you find out?
>
> BUDDY: Yesterday. I had my test two weeks ago, and found out yesterday.
>
> SAVANNAH: What made you all of a sudden want to go get tested?
>
> BUDDY: I got this wart on my dick.
>
> SAVANNAH: Hol-lee.
>
> BUDDY: And crabs.
>
> SAVANNAH: That's gross! Cause you sleep around. Don't you use protection?

BUDDY: Well I do, we used protection…mostly.

SAVANNAH: Yeah I know, but like you're telling me this now? You're HIV positive? What if I am? She demands that he leave. Before he leaves, he tells her that she will regret it. HIV has become a death sentence and he seeks solace in prayer. On his knees with his hands clasped together, Buddy prays to God asking for forgiveness and help. He is an individual existing in an unfathomable universe but despite the consequences he is ultimately responsible for his acts, good or bad. Although he is seeking existential help, his faith is in the trenches. Rather than wait to see if his prayer will be answered, he reverts to what he knows and goes drinking. This time his unhealthy coping mechanism leads him on a self-destructive path. He loses control of the car, crashes and dies. In my analysis, the prayer and subsequent crash allude to irreverence towards the sacred; man dies in the trenches even when reaching out to God. Buddy might have sought solace in a priest or elders but he did not approach either Christian or Indigenous representatives of morality and spirituality. Buddy is a tragic hero whose fatal flaw is drinking.

The connection to Indigenous culture with respect to the attachment to the cosmos and land that are important to many Indigenous peoples is absent from the Buddy and Savannah story. Author Leilani Holmes (2000) addresses Hawaiian Indigenous knowledge as originating in the heart,[60] blood,[61] and land and stemming from the family, physical senses, prayer, prescience, dreams, and messages from the dead (p. 37 - 46). In the context of Cree people, I would add animal spirits. The author states that this knowledge is "familial and hierarchical" (p. 37). Since this knowledge flows in the ancestral blood and is passed down from family member to family member from the heart, Buddy has not had this opportunity to have any of this hierarchical knowledge because of family breakdown and an absence of cultural knowledge. Although he has roots to his community, he has not had the experiences that tie him to the

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[60] Holmes states that knowledge specifically heart knowledge is not an intellectual exercise but contained in the emotions and passed down through generations.

[61] Blood memory refers to one's connection to the land and that it is contained in one's blood, roots, and experience (p. 42). Each family has different memories to pass down as knowledge. Holmes states that this knowledge is not validated through the truth value but through the connection of family member to family member (p. 42). "The memories that are passed down are inviolable" (p. 42).

land. He grew up without a father figure to show him the gender specific roles to tie him to the land and his mother was at a loss to provide this. Holmes (2000) states:

> Knowledge is intended to incite humans to act in such ways as to ensure the protection and reproduction of *all* creatures in the universe. Political and social history does not exist in a different realm from Indigenous cosmology; rather, it *intersects* with that cosmology. (pp. 37-38).

If Buddy had grown up with gender specific cultural knowledge, he might have been able to cope with the HIV diagnosis and find support through elders and other Indigenous practitioners of spirituality, not through Christianity practiced in the trenches, during times of grave trouble. The effect of religion on the culture is examined through this part of the analysis.

The political and social history of Canada's Aboriginal people is one based mostly on cultural oppression. The Public Health Agency of Canada defines culture from the negative perspective of a dominant society exerting power as an Anglo Saxon force over marginalized Indigenous cultures.

It is widely known and accepted that church-based residential schools had fatal consequences to Indigenous peoples.

The determinants of health perspective, offers a number of lessons. Communities ought to encourage healthy child development, develop a positive social support network, strengthen education and literacy, and enhance positive coping skills. In a community where the physical environment poses a risk to sexually active individuals who do not practice safe-sex, increased STI/HIV prevention health care services are needed to create a safer social environment.

In the last of the three stories, Alix's Story, it seemed that Alix would never escape the abuse linked to the lifestyle associated with alcohol and drugs. This story is about a young pregnant woman who finds out she is HIV positive. The scene begins with a glimpse into her childhood. As a child growing up, the people in her immediate environment were crack heads and abuse perpetrators. Because of addiction to crack cocaine, her mother risked her daughter's life by exposing Alix to a boyfriend who was a child sex abuser. He used unemployment as an excuse to become the caregiver for Alix while her mother went to work. One day while her mom was away, the boyfriend fondled her. In monologues to the audience, Alix takes us from one scene to another and comments on how, although they never saw Ronny again, this experience affected her during her teenage years.

In the next scene, she describes another encounter with the opposite sex that occurred when she was a teenager. Her first boyfriend wanted to have sex with her after going out for six months but she was not ready for it and he broke up with her. From these negative experiences, she learned that men were after one thing. She began drinking and doing drugs. One night, while at the bar, her friends abandoned her and a stranger picked her up. He had sex with her and threw her out of his truck. Alix's mother found her daughter in the front yard intoxicated to the point that Alix could not remember what happened that night. This series of incidents leads her to her HIV positive status, something she is not aware of until much later in her life.

When life seems to be going well for Alix, she discovers that she is HIV positive. In her young adult years she meets Jason, someone who becomes an important part of her life. She becomes pregnant and is very excited about it. At the same time that she learns of her pregnancy, she also learns the dark truth – that she is HIV positive. What is supposed to be a good surprise turns out to be the opposite. From the doctor, she learns that she can minimize the risk of spreading HIV to her unborn child if she takes a cocktail of drugs.

Deciding to keep her baby and hope for the best, she seeks support from her family and friends. She tells them about her condition and the disease; they are accepting and supportive. The closing scene is Alix's narrative: her son is eighteen months old and he does not have HIV. With less of a burden on her shoulders, she is ready to promote acceptance of people living with HIV/AIDS. Alix is a hero who rises above adversity and takes positive action for herself, family, and community.

Alix speaks directly to the audience about a friend she has, a researcher, who is organizing a gathering for HIV/AIDS prevention who has asked her to speak at the gathering; she has agreed. From the abstract world of theatre to the concrete reality of an upcoming gathering, Alix's Story serves as a point of departure to introduce the actual community gathering for HIV prevention that was to be held in the following month. The play ends. After the applause, the researcher explains the upcoming event and leads a post-theatre discussion.

Addressed from the determinants of health perspective for STI/HIV prevention, Alix is a tragic heroine. Her childhood is traumatic. She grows up in a working class environment where her mother's perverted unemployed boyfriend takes advantage of her mother's need for childcare to satisfy his perversions as a child molester. Had Alix grown up in a family where the mother could afford daycare or to stay at home to raise her own child, Alix could have avoided this morally despicable crime which was committed against her. In this situation, improving the mother's income levels and social status, and increasing employment and working conditions for men within the community, could help to alleviate suffering and hardship and improve healthy child development. Alix's tragedy was that she grew up in a poor working class environment where psychosocial health problems abound, but she rises above it all, knowing that the events of her early childhood years were not of her own doing and she was not responsible for them. As a young adult, she takes action and becomes a responsible person living with HIV - and a community hero.

Relating the Play within the Indigenous Iterative Webbed Circle

Spider Woman has spun a silken web attached to the red willow and, like that web, we are connected to one another. In the context of the Indigenous Iterative Webbed Circle, we as individuals are responsible for ourselves; we are related to our families and have obligations and duties to family members; we are inter-related within our communities and we share a common history, language, way of life, and united purpose. All the characters within "My People's Blood" are a reflection of these complexities. Like Spider Woman herself, the play is a creation of thought itself.

Table 1

Themes in "My People's Blood"

Theme	Kehew & Pisim	Savannah & Buddy	Alix's Story
Alcohol is used in the story	Yes	Yes	Yes
Drugs are used in the story	No	No	Yes
Alcohol consumption leads to STI/HIV	No	Yes	Yes
Drug use leads to STI/HIV	No	No	Indirectly Yes
Sexual promiscuous heterosexual behaviour leads to STI/HIV	No	Yes	No
Non-consensual sex or rape leads to STI/HIV	No	No	Yes
Sexual promiscuous heterosexual behaviour causes relationship problems	Yes	Yes	No
Intergenerational trauma in childhood adversely affects self-esteem and adult relationships	No	No	Yes
A character has HIV	No	Yes	Yes
A character accepts his/her HIV positive status	n/a	No	Yes
Family and friends accept the disease	n/a	No	Yes
A hero emerges to prevent HIV	No	Yes	Yes
Someone wants to prevent STI/HIV by making a lifestyle change	Yes	Yes	Yes

The similarities found in all three stories include the creator/participants' view that HIV is a disease that intoxicated heterosexual Indigenous people become infected with as a result of lowering their sexual inhibitions and/or their responsibility for personal sexual safety. Since the disease knows no bounds, and any person practicing unprotected sex is liable to become infected, the group focused their stories on alcohol consumption. It is a disease that nobody wants and one that people fear. The Kehew and Pisim story addresses the idea of staying monogamous and quitting drinking to prevent the disease and save a relationship. Not presenting the Kehew and Pisim story at the community performance resulted in losing a message about changing one's lifestyle in response to a disease threatening the community. If community members had viewed the Kehew and Pisim story, some might have felt encouraged to change their lifestyle or promote that message. Rather, the community audience viewed the story about Savannah and Buddy followed by Alix's Story. In both stories, a central character is HIV positive and a hero emerges. In the Buddy and Savannah story, Alice, Buddy's mother becomes a hero after Buddy's tragic death and wants to start talking circles for parents. In Alix's Story, Alix becomes the hero for HIV prevention and a public spokesperson for her community, a role which would take her across the nation. Heroism equals positive action.

Although HIV affects both bisexual and homosexual people, these two stories do not link HIV to bisexual or gay people, nor is it depicted as a disease spread through sharing needles. The stories force community members to think about the heterosexual transmission of HIV and the possible transmission of the virus from mother to child. In this story, the community members empathize with Buddy and his friends and family members who are affected by his disease and death. The community members also worry about Alix's innocent newborn baby whose health status is unknown even though her mother took a cocktail of drugs to prevent infecting her unborn child during pregnancy. After finding out the 18 month old is HIV negative, the audience wonders what Alix's future will be like as a spokesperson for HIV.

The stories differ in that neither character has HIV in the Kehew and Pisim story, even though both central characters were unfaithful. Buddy was not so lucky; he was HIV positive in a community where people shun and gossip about those who have HIV and those who might be infected. With Alix's Story, the audience views a moment in Alix's traumatized childhood and they understand the psychosocial factors that contributed to Alix's eventual rape and HIV positive status. The audience becomes aware of how a dysfunctional home and sexual abuse can cause problems for the abused person at later stages of life. Although this story does not speak to the historical consequences of intergenerational trauma linked to the residential schools, the audience members who have been to the residential schools know how that experience affected them. That the members of the core group had not experienced the residential schools first hand may have been the reason why intergenerational trauma reaching back to the residential schools was not directly voiced in the play, even though the creators of the play had heard the voices of the elders in the talking circles. Had the residential school experience been directly voiced through one of the characters, critical thinking of the historical consequences would have been clearly expressed by the viewing audience.

The two stories that were presented for a community audience suggest that social change can occur, through HIV testing, talking circles and gatherings for STI/HIV prevention. If audience members had had the opportunity to view all three stories they would have also experienced a message of hope for change in a one-to-one relationship. They did see Buddy's mother use her loss as a catalyst for social and health change by wanting to start a talking circle for community members on STI/HIV issues. The community members also saw how supportive family and friends are catalysts for social change. Because of the support Alix, who has HIV, receives, she overcomes any doubts and alienation and is able to contribute to society. The story's incorporation of HIV testing and its importance reflect the creators' decisions to get HIV testing during this project as discussed in Chapter Five.

The Community Performance.

Popular theatre is often, as in this case, presented to elicit community discussion and action. Plays present themes and messages and the creators of the plays want to engage their community audiences in a discussion of an often avoided issue. The three stories that were developed tug at heart strings for many reasons, including that these young people developed these stories with creativity and white-knuckled determination, despite many barriers leading up to the performance. The two plays were performed with heart-fluttering courage and honesty. The co-researcher/actors delivered a spell-binding message to their community about the need for STI/HIV prevention and acceptance of people living with HIV. Not only was the production entertaining, it allowed the audience members to see their own community members presenting a serious social health issue that is often not spoken of. The issue was made public via the local newspaper, and by their brave performance. Two hundred people shared an experience about an issue, told In terms of their own community. The event was a far cry from a typical evening of satellite television, games/sports or radio bingo. July 6, 2005 in this Northern Alberta community was a night of magic. It was the community's night to be amongst their own elders, leaders, families, young people, and health care professionals. It was a time for them to stand in prayer in common unity for a greater cause that took them outside of their comfort zones into the heart of "My People's Blood."

It was like inviting an old friend over; there was so much to do and see. In addition to the PowerPoint presentation, graffiti walls, prayer, feast, play and post theatre discussion, there were health care professionals from the Health Center and Ribbon of Hope Society in the house providing information to community members.

As they gathered together, the community members walked around the circular tables hugging, shaking hands, and greeting one another. Some watched the PowerPoint presentation of the core group's light-hearted moments of creativity peppered with candid shots from the smiling, creased faces of our loving and supportive elders. It was like sharing a cluttered box of cherished photos. Among the memories displayed on the bigger than life screen were shots of the Canada Day parade. It reminded me of the openness of spirit it took to hand little packages of STI/HIV prevention goodies, including condoms, to their community members in broad daylight! After viewing the presentation, the anticipation in the air grew thick like fog and then, a hushed spell-binding quietness captured everyone's attention when Elder Alice Reid was asked to pray. The food was blessed and, yes, they ate gloriously as in the good old days when wild game was plentiful. The smoked fish had penetrated their senses in a most intoxicating way, the almost familiar way of their ancestors. Their blood remembered what it was like to feast on traditional foods. That fish allowed them to feel the spirit of the life in that food, so consoling in the era of AIDS, so consoling in times of imminent change, so consoling to be amongst one another. That fish gave us life and we were blessed. After my introduction and a speech by Chief Francis Gladue, the lights dimmed and the stage lights focused on the hot pink, turquoise and yellow stage screens built by a local community member and the hand-made masks made by the core group members. It was their time to shine and show the community what the talk in the community was all about.

While the stories partly addressed the many factors that precipitate STI/HIV infection, we did not raise critical awareness of the efficacy of the health care service delivery between the government and Aboriginal people. What we created was a platform for social and health issues to be discussed. There were many stories that could have been told but these were the ones that were developed and performed for the community.

Chapter Eight: STI/HIV Knowledge Translation and Exchange in an Indigenous Community

At the heart of this project was the creation and performance of the play, “My People’s Blood.” Conducting a performance in the community enabled Spider Woman, a true creatrix, to create a “sacred space” that brought together elders, youth, parents, health care providers, and leaders. They witnessed the STI/HIV prevention play and discussed the messages within the fictionalized stories, while bringing the subject back to the reality of STI/HIV that exists within the community. The creation of the play and audience involvement demonstrated how research that is translated and exchanged becomes more meaningful and applicable for everyone. This chapter defines knowledge translation and knowledge exchange, explained from an Indigenous perspective. From this Indigenous point of view, knowledge translation applies to the action research/popular theatre process of story development, whereas knowledge exchange applies to the performance and post-theatre discussion. The data suggest knowledge translation and knowledge exchange, through popular theatre and action research, are appropriate ways to engage in a decolonization process. They open up the valves of communication that enabled a cross-section of community members to address STI/HIV.

Defining and Re-Defining Knowledge Translation and Knowledge Exchange

The Canadian Institute of Health Research [CIHR] defines knowledge translation as:

> The exchange, synthesis and ethically-sound application of knowledge – within a complex system of interactions among researchers and users – to accelerate the capture of the benefits of research through improved health, more effective services and products, and a strengthened health care system (Graham et al., 2006).

The Canadian Health Services Research Foundation (CHSRF) defines knowledge exchange as:

> Collaborative problem-solving between researchers and decision makers that happens through linkage and exchange. Effective knowledge exchange…results in mutual learning through the process of planning, producing, disseminating, and applying existing or new research in decision-making (Graham et al., 2006).

These terms are considered in concrete and abstract ways; they are similar yet different. In this research process knowledge translation and exchange occurred with the core group, while knowledge happened between the group and community audience. The differences are discussed below.

As an Indigenous researcher my goal is to define knowledge translation and knowledge exchange according to my epistemology and ontology. As I write about how I create knowledge I think about some wise words that elders have shared with me. I link the elders' phrases to answer my own question: why is it important to translate and exchange knowledge?

Elders[62] talk about Indigenous identity and why it is important to know who you are as an Indigenous person. Knowing our culture, history, and language has always been stressed to us as younger people because we are products of colonization. Therefore, knowing our identity gives meaning to our lives and helps us compensate for the "sad period" when our parents and grandparents were brainwashed to believe they were inferior and punished for speaking their language. Although they were strong in mind, body, and spirit, our grandparents were silenced when they were children by the Church and state. They grew up deprived of their heritage and family and believing the worst about themselves. We are at a point in our decolonization process where we "kiyanaw Nehiyawak"[63] have the ability to re-learn the Indigenous knowledge along with the Western knowledge. With this collective body of knowledge we become aware of the strength of our voices. We understand that we are just starting to speak and write within the Western academic milieu. Therefore, there is hope for survival.

From this ontological perspective, I explain how I create knowledge so that I may honour my Indigenous epistemology. By knowing my cultural identity and place in history, I, as an Indigenous woman can connect my being and knowing within the academic exercise of explaining knowledge translation and knowledge exchange.

Knowledge translation, from my Indigenous perspective, begins when you are in contact with your higher self, as when you are doing something significant that engages your mind, body, and spirit. I

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[62] Ken Saddleback and Clifford Cardinal
[63] All Cree people

equate this significant event to connecting to the land[64] in a meaningful way like when I gather berries or sage to use in ceremonies by myself or with other people. When you are connecting to the physical or social environment there is a transfer of energy and everything must be done with a good mind, an ethical mind. By connecting to your higher self and maintaining a good mind, body and spirit, the work that you do is blessed. As an Indigenous researcher in the process of transferring knowledge and/or exchanging the knowledge, I tried to maintain a connection to my higher self through prayer and smudging as I worked with the core group. I think the group members were connecting with their higher selves, too.

Although the CIHR definition of knowledge translation presented at the beginning of this chapter sounds like a mechanical process, it is not. It is a process full of life with many twists and turns. The research setting is the community, alive with a rich socio-cultural background. In this setting, the Indigenous health researcher shares theory, methods, and personal experiences with the core group in a sound ethical manner. The core group members, who are a representation of the young adults of the community, share their ideas, thoughts, feelings, and life stories on sexuality and STI/HIV prevention. In other words, knowledge translation captures the essence of life for the greater good. Each person involved in the STI/HIV prevention project provided knowledge and experience to shape the stories that formed the essence of the play, “My People’s Blood.”

In this research project, the information was obtained from the wells of experiences the core group members had living within their community, learning about STI/HIV from health care professionals, understanding the past and how it affects the present, creating characters and scenes, sharing personal experiences with STI/HIV testing, and sharing their reactions on the effect of the local media on community members. After having been involved in the action research/popular theatre project and listening to what community members had to say about STI/HIV prevention, I watched the group members create a play and perform for a community audience. Through this complex network of people and events, the co-researchers and community seemed to have received a gift that resulted in greater

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[64] Blackfoot scholars Blood and Heavyhead who deconstructed Maslow’s Hierarchy of Needs emphasize “place” or connection to Mother Earth as integral to personal development.

awareness and sensitivity along with an appreciation for the action research/popular theatre methods. The methods involved decision making among the group members on day-to day group activities and story development. The result was a mutual learning experience for everyone involved in the processes of investigation, community research, creation, and performance.

Knowledge translation from an Indigenous perspective is a process which takes information and experience, boils it down into a tea and once it is ready, the tea is served. The serving of the tea to the community audience is the knowledge exchange whereby that audience benefits from the group's effort in gathering knowledge, sharing it, creating a play, and distilling it to near perfection. The benefits of the tea are shared just as the issues from the play are discussed re-translated and exchanged among community audience members for the community's benefit and the greater good.

In order to foster the development of healthier Indigenous communities, the dynamic participatory process of the post-theatre discussion served as a springboard to knowledge exchange. At the outset, my research goals were to determine whether these methods were appropriate for STI/HIV prevention. Specifically, I wanted to answer the research question: is popular theatre an effective way to encourage audience members to express their attitudes, knowledge, and behaviours related to sexual health? The answer was encouraging as audience members participated in a post-theatre discussion that encouraged community dialogue.

To be effective, the researcher and co-researchers had a common goal - to link information through the performance and a post-theatre discussion with a community audience. This sharing of one's higher self with others is vital to the process. From community performance and post-theatre discussion, to writing this dissertation, the exchange continues, from researcher to university, and perhaps community to community.

A Synthesis of Knowledge Translation and Knowledge Exchange

Using data sets that include one-to-one interviews, journals and dialogue within the plays, I provide examples of knowledge translation and knowledge exchange to show how the project influenced the attitudes, knowledge, and behaviours of the core group members in a way that allowed them to make healthy sexual choices. Feedback from the community and core group members demonstrates the effectiveness of popular theatre as a way to encourage audience members to express their attitudes, knowledge, and behaviours related to sexual health. Presented below are profiles of the group members with reference to the central character they performed. I present the Savannah and Buddy story first with profiles of Rocky/Buddy (character), Willow/Savannah (character), and Diane/Alice (character). This is followed by the Alix Story featuring the profile of Jasmine/Alix (character). Lastly, the Kehew and Pisim story are presented with profiles of Leila/Pisim (character) and Doug/Kehew (character).

Rocky joined the project because he was interested in acting and thought the project sounded like fun. I asked him how he felt about addressing STI/HIV prevention. He said he was interested in learning about it. I pressed further, wanting to know if he thought STI/HIV was a concern to him. He told me that it concerns him as an individual. He said that he wears condoms most of the time to feel safe sexually but there were times when he did not. Although he was interested in developing a play to address this topic so that young people would hear the messages, he said that ultimately it is their life and choice to practice safe sex or not. Considering that people go to parties and go home with someone, he said, “Who knows if they have a condom or not!” The discussion made him recall a close call he had impregnating a female he hardly knew. From that experience, he realized he could have also become infected with STI/HIV. After that experience, he was tested for HIV and was found to be negative.

Five weeks after being involved in this project, Rocky went out of his way to get condoms. The condoms were free at the local court house. In addition to picking up free condoms, he would talk to his friends about using them to avoid STI/HIV. Since becoming involved in the project, he had started thinking about safe sex. He stated that, “It makes me think and I told a couple of my friends to watch it, watch it: Watch who you sleep with.” He got the impression that his friends did not care.

Half way through this project the group decided to get tested for STI/HIV and it was a “big thing” that made Rocky “kind of nervous.” By example, the group was showing how important it is to test for

STI/HIV and provide support for one another and feel confident enough that in their current or future relationship they can ask their partners to get tested for STI/HIV.

When the project was over, Rocky told me that, “it was fun working in a group, being in a group all of the time, especially every day, in those circles, talking.” When he first started the project, he was focused on acting but he found the group work and talking circles enjoyable. Maybe, this should not be surprising. After all, he was a young 18-year-old Aboriginal man who had not completed high school, had been in trouble with the law, worked full-time in an entry-level labour position during the day and then attended our project most evenings and weekends. This project offered a time and place to be with other people mostly his age to talk about ‘stuff,’ learn about sexual health and creativity. Belonging to a group was empowering for Rocky.

When Rocky first joined the project he talked about “cleaning up his act.” This group was probably an important part of his personal development. During the process of scene development and talking circles, Rocky talked about drinking, partying, prior experience with STI/HIV testing, and his troubles with the law. It seemed to me that part of the reason he used alcohol was because many friends and family members had died from cancer, suicide, pedestrian accidents, or car crashes. It seemed to me that the community itself is a difficult place for young people to stay clean and sober because alcohol use is the social norm. One time, his choice to use alcohol resulted in a serious car crash.

Rocky crashed a car into a ditch. Luckily, he was physically unharmed and he hopped out. Moments later, the car exploded “like a fireball.” The crash made the front page of the local newspaper. His lived experience was transmitted into the fiction of the play later created.

In the play, his character Buddy dies in a car crash. He tells his friends and mother he has HIV and they shun him. Below are the lines from the play.

BUDDY: Savannah!

SAVANNAH: (*She looks out window sees him, sighs but does not open door*). What?

BUDDY: Nothing I just wanted to come and see …see how you’re doing.

SAVANNAH: I don’t want to talk to you. Don’t you know… you could have ruined my life man. You fucking ruined yours. I don’t want to be around you anymore.

BUDDY: (*He tries to get her to listen*). Savannah.

SAVANNAH: I don’t want you around my house. I don’t want you in my life anymore. Stay away from me.

BUDDY: Savannah.

SAVANNAH: Stay away from me!

BUDDY: Please. (*He shouts*). You’re going to fucking miss me when I’m gone. (*Buddy gets back in his car, starts it and crashes car, transform to the funeral).*

It is a moving scene. The events leading up to Buddy’s death and the car crash reflect the brutality of living with HIV in this Northern Alberta community. The knowledge exchange between actors and the audience was that, in this case, the virus did not kill Buddy, the stigma did.

Working with young people involves working with their life histories. One of the young women in the group whom I interviewed told me she had been abused both sexually and physically. Even though I expected to work with people who have been abused, it was sometimes challenging. Willow was very self-aware and had natural talent as a leader. She commanded a leadership role in our group and so when she was not feeling positive it affected the group. She became more self-aware of her anger. After the performance she reflected on the project and how it had affected her in many ways. She stated:

> *It affected me in lots of ways. First of all, I still know like I have a problem with anger and I have always known that. I have been told that lots. It is just a reminder that I have to do something about it. Like I thought I had it in control but obviously I don’t, like everything shows in my face, and someone can tell when I am mad. It is just something I need to work on, just a reminder and like it just helps me grow as a person too. I feel healthier and I feel more important because I want to play a better role in the community. I want to be involved with the community. I just want to be better and I want to be healthier and live a healthier lifestyle and be stable, and not feel like I have to go out and be with my friends, go out drinking or whatever. I am starting to think more.*

> *It is helping me grow up like that. It made me think more and it helped being there in the evenings, it took away from that cruising around or going to the beach, whatever or being social. It took away a lot of that time I used to have. I realize that I can live without it.*

In our first interview, she said that she believed the drug problem in the community had to be dealt with first before the STI/HIV issues could be addressed. She told me this in her kitchen as she swept the floor looking wise beyond her years in her reflection about the community. On a personal level, Willow was applying a central teaching of the Indigenous Iterative Webbed Circle, examining the role of alcohol in her life. Taking an honest reflection about her alcohol use was a significant change in attitude.

Throughout the project, this young woman maintained that monogamy and knowing that the person she was with was, “clean,” was her way of feeling safe sexually. Prior to being involved in the project, she had taken sexual risks and not sure if she was truly HIV negative. She had had one test which indicated she was negative but she did not have the six-month follow-up to confirm her results. Mid-way through the project, a local nurse conducted an STI/HIV presentation which prompted a group decision to be tested, as explained in Chapter Five. Getting tested not only helped her connect to a higher power, but also to become emotionally committed as a stakeholder in the project.

In the play, Willow plays Savannah. Savannah is angry at herself for not using a condom all of the time and worried about her health. In the funeral scene (for Buddy) her character, Savannah, stands at his grave with friends. They state:

> PAUL: I shouldn’t have pushed him away. I should have been there for him I feel like it’s my fault.
>
> SAVANNAH: I’m sorry Buddy. I never told you how much I really love you.
>
> LORAINE: He’s all covered over with that thing. I wonder if it’s still catchable right now.
>
> SAVANNAH: My results come back next week. I pray I didn’t catch it too.

After the funeral, Savannah goes to the doctor’s office to find out her HIV test results.

Willow enjoyed performing for the community. “It was exhilarating, just the feeling of accomplishment and the look on people’s faces. They were shocked. They weren’t expecting that,” she recalled. “Then when the lights came up and they were clapping. They were proud. I was proud and I was proud of all of us.”

In her opinion, popular theatre and action research[65] addresses STI/HIV prevention effectively in an Indigenous community. “It works, it definitely works. I got the feedback from the community and they said we need to do more of it. There needs to be more.” Performing for the community involved exchanging knowledge about STI/HIV prevention. The actors created a play and performed it for the community by connecting to their higher selves and sharing it with others.

Diane, one of our group members, is a mother of four boys. She was asked to join because we did not have enough young people between the ages of 18-25. Even though she was working three jobs, taking a course, and looking after her boys, she joined in when she could. She had two main reasons for being involved in the project: to be a role model, and to dispel resistance to STI/HIV prevention. She stated, “I am a parent and having all boys, I don’t have any girls, I am hoping my boys will realize that these condoms are not to be blown into balloons!” In this way she wanted to be a role model to her children. The second reason was even more personal, a friend had HIV. After we performed the play she learned that her friend’s white blood cell count was down. Diane explained that:

> *[This person] is not dying but I know it is coming. I don’t know how to plan someone’s death. I have never done that before. We are trying to make every moment count but it hurts so much. We are trying to make peace. I don’t know how to do it. I am trying to bring religion back in my life. I don’t want to be mad at God but I am for creating this.*

She was philosophical yet depressed. Her friend had lived a high-risk lifestyle in a major city and contracted the disease. Her friend’s disease was taking some of Diane’s immense strength away and she questioned how long she could last before she broke down:

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[65] Community-based participatory research is included in this reflection because it is a co-learning process that aims to “reduce health disparities” (Minkler & Wallerstein, 2003, p. 7).

> *I don't know but He (God) gives you so much to handle and we are only human beings. How much more can a person handle? My mom says He doesn't give you more than you can bare [but] how much more can I bare without falling apart?*

After the Canada Day parade, Diane began to disclose to the group that her friend had HIV. She did not state who her friend was but she was feeling the strain of dealing with her friend's declining health and trying to create a monologue for the play.

At the time of the final interview, she was also in a relationship that seemed to be heading to a break-up over irreconcilable differences. The stress of her friend's health was affecting her personal relationship. She was the only group member who chose not to test for STI/HIV. She had tested negative for HIV three years before the project began and chose not to be tested again. She felt safe in her decision. She still had concerns about the transmission of HIV among older adults because of stories she had heard and what had happened to her friend. She said:

> *Even though you think you are with somebody who is safe, you're not with them 24/7. You don't know if they went and fooled around on you. You hope they don't. You would hope that they would never do that to you.*

Feeling secure in her monogamous relationship, she realized that older people are not immune to the disease if they are promiscuous.

Diane identified her involvement in the project as "powerful" and she hoped that the audience members understood the message. She played Alice, Buddy's mom. After the scene at the funeral, she performs a monologue.

ALICE: After my son died, for a long time I felt numb. I kept expecting him to come jumping through the door with a smile and joke. I cried until I didn't think there where any more tears left in the world. Then I got mad. How could this have happened to Buddy? Lots of people around here have unprotected sex, and it's not just the kids. Older people, people my age, who should know better. They screw around on their wives or their husbands, have affairs. Why Buddy? His life just began. I haven't even met his future partner. It wasn't fair. And I

> blamed myself. That day when he told me, I could have hugged him, I could have told him he was my boy no matter what. I wish I had educated myself more and told him why unprotected sex can be deadly. But what did I do? I deserted him. I thought the guilt and the anger would kill me too. I was mad at God, I was mad at the virus. It destroys families, it destroys relationships, and it destroys people. I was mad at his friends who pushed him away and my mother who didn't want to hear about it. I was mad at that Savannah, supposed to be his best friend. Where was she when he needed her? Where were all of us? I should have been more open with him. I never talked to him about sex. Well that was his father's job and his father wasn't around. I didn't tell him about HIV because I didn't know. I thought about all the other parents who don't know. I went to see Shelly Gladue and talked to her. She told me all about this disease. Now, I want to save another parent from going through what I went through. We can't let our young people down. We have to talk to them, teach them, and try to save them. What can we do? I don't know but I want to start a talking circle for parents about HIV. Together we have to come up with a way to do something. It's too late for my Buddy but there's lots of Buddies in this community, lots of Savannahs. I want to start a talking circle but I'm scared. What if nobody comes?

The monologue was insightful. Although the group wanted young people to become more aware of STI/HIV, there was a message to the older community members. In dealing with her friend's HIV positive status and declining health, Diane realized, "there are no services out here at all." She felt like she was running an emotional treadmill by herself, without support except through this group. The support of the group and the methods we used empowered her to deal with the challenges she was facing.

One of Jasmine's family members died in 1992 of AIDS. The loss of her cousin was her main reason for wanting to be involved in the STI/HIV prevention project. A second reason for choosing to be involved was to address teenage pregnancies.In our one-to-one interviews, Jasmine talked about her family background. Although she had the support of her family, she sometimes felt that because she was from a prominent family she was criticized and judged by the community when she did not measure up to what was expected of her. There was a time in her life when she used drugs. At the time of the interview, she had been "clean" for eight months. She equated the criticism and judgement she experienced as a drug user to the stigma people living with HIV experienced. She wanted to dispel this stigma. Jasmine said:

> *No matter if they're young or old or what colour they are, everybody is still affected by HIV and STD. No matter if they have it or not. So that's what they need to know, to not like throw people away, I guess.*

I think her underlying goal was to promote family and community values. Although these values were not taught in, group, her goal was in accordance with the teachings from the Indigenous Iterative Webbed Circle. As a critical thinker wanting to dispel stigmatization, Jasmine's idea was to understand "the actual roots of everything." She believed the STI/HIV prevention project would benefit the teenagers in the community.

Jasmine helped create Alix's Story, as part of the play, "My People's Blood." She played the central character, Alix. As discussed in previous chapters, Alix is infected with the virus that causes AIDS. We learn that, as a child, Alix grew up in an environment where crack was smoked and when she was molested by the mother's boyfriend. As a young adult, Alix is drinking with friends and then left alone only to be picked up by a rapist. She is infected with HIV but does not know it. Time passes and she ignores what happened to her. She develops a personal relationship, becomes pregnant, and finds out that she is HIV positive. Although her baby does not have the virus, Alix becomes a spokesperson for people living with HIV. The following is Alix's narrative to the audience:

> ALIX: This is my baby boy, Nakota. He's eighteen months old. I just found out, finally, after how long waiting, that he is healthy, he's HIV negative. Now I can try and fight this disease with less weight on my shoulders.
>
> I not just fighting for myself I'm fighting for him. I wonder: what if people talk and ask him when he's older: "how did your mum die?" And he won't know how to answer because nobody told him about me having AIDS. Or what if people ask him if he's HIV positive? How would he answer? I've got to let people know. I want him to know and I want the

> community to know. I might die next week and I might live for years but I know we need to do something about HIV here, for me, for my son, for all of us.
>
> I have a friend who wants to organize a conference here in Wabasca, a conference about HIV. She talked to me. She wants to invite leadership, health professionals, HIV experts, people living with HIV, and community. It is open to everyone. She wants me to speak at the conference. I don't know, it would be hard to stand up in front of my friends and family and tell everyone my story. But I'll try, I'll try for Nakota, because he needs hope, and so do I. If there were a conference would you come?

Her closing statement introduced the action research spiral of planning through hosting another gathering the following month.

After the performance, many community people expressed their pride to this group of young people. The play enabled the young people to earn respect from their community members. Someone from Jasmine's late cousin's family[66] commended her for being involved. Jasmine never thought Beverly would talk to her of STI/HIV prevention because their mutual family member had died of AIDS. I suspected there was some tension between the two, but after watching Jasmine perform, Beverly told her that she understood the personal reason why she was involved in the STI/HIV prevention play and added that "you're not only thinking about yourself you're thinking about other people." Beverly's words had a healing effect on Jasmine as she earned the respect of her extended family members.

The Kehew and Pisim Story developed by Doug and Leila was not performed for the community. Doug chose to participate in this project because he wanted to help address the STI/HIV issue. "I think that everybody should know the consequences," he said and added that even though people know the consequences of unprotected sex they still do not use condoms all of the time. This seemed to be a common belief among the young men of our group. Doug developed the character Kehew, who does not always use condoms and his confession is below:

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[66] For the purpose of this conversation, this person's fictitious name is Beverly.

KEHEW: Do you remember that time when we had an argument about your drinking?

PISIM: Which one?

KEHEW: That big one about 8 months ago. And then, I just left and told you I was going to visit my friends for the weekend?

PISIM: You told me you were going camping.

KEHEW: Yeah, so I said.

PISIM: What were you doing if you weren't camping?

KEHEW: Some of the guys got together .and just went out to the bars in the city, and got hammered all weekend.

PISIM: What?

KEHEW: I'm sorry I should have told you.

PISIM: I'd have dumped you if you told me.

KEHEW: *(long pause sigh)* Well one of those nights… I was with someone.

PISIM: Who?

KEHEW: I don't know who she is really; I just met her at one of the bars. We got drunk and went to a hotel room.

PISIM: Did you [sleep with] her?

KEHEW: Did I sleep with her? Yes, I did.

Pisim is not innocent; she confesses her infidelity; both characters test negative for HIV.

The fear of AIDS was the primary reason for Leila's involvement in the project. In our first one-to-one interview she shared her fears:

> *I am actually scared that somebody I date might have it and I might not know. They might not tell me because it is embarrassing to like have that. You wouldn't want to tell. I wouldn't want to tell if I had it. I would be embarrassed, myself, so I need to be more aware of like AIDS especially in this community because I hear that it's here.*

Her involvement in this project was a way to face the reality of living in a high-risk community. She realized that with so much freedom and liberty there are consequences to be aware of. During this first interview, she stated that six months previous to the project she contracted an STI which seemed as a serious warning for her. I asked her what she did to feel safe sexually and she responded, “I don’t know if I’ve ever felt safe sexually.” Then she added that she mostly uses condoms and takes the birth control pill. She explained how she had had a blackout and recalled one incident of unprotected sex to explain why she has not felt safe sexually.

At the time of the interview, she was in a one-to-one relationship and was hoping that it would be a long term one. Five weeks later, I asked her the same question and she said that she was in the same relationship but they had broken up briefly and during that time she contemplated whether or not having a sexual relationship was that important to her. It seemed that she was more concerned about having a partner to be emotionally close to, “I thought [sex] brought you closer together,” but from her experience she realized that “it can also tear you apart too.”

Five weeks later, she expressed how the project had had a positive impact on her. She had a safe place to turn to and keep busy. She learned about STI/HIV through the presentation by the local nurse and was able to share this knowledge with her friends. She was also in the habit of keeping condoms available. When the group decided to get tested she had told her kokum that she was having another STI/HIV test even though she had had one a few weeks before. By being involved in the project, she was able to talk to her kokum about sexual health, something she was not able to do before. Her kokum and mother approved of her being involved in the project and encouraged her to attend. They knew it had a positive effect on her. Some community members thought that to be involved in the project one had to have HIV. When she corrected the misperception and informed them she did not have the virus that causes AIDS, in the back of her mind, she still questioned herself. Leila explained:

> *When they say the AIDS thing, I say of course not! I don’t have it. Then I start thinking what if I did? I would just kill myself if I had it or something. When I first started coming here I started worrying what if I do have it. All these questions just popped up and I was like, ‘Oh my God, I*

> *sure hope not!' I prayed. As soon as I got the test, I couldn't concentrate on anything else like I wanted the results right the same day so I know I don't have it.*

Leila went for a second test with the group and supported the others. After the testing that day, we met at the Old School. She arrived late. This is what she wrote about being tested:

> *All of this jazz about getting tested made me realize, you really need to respect your body, it's the only one you have. I am going to pray that [no one] in the group has HIV. My friends need to be more aware too. I feel like spreading the word.*

Leila did not stay with the project to the end but she developed the Pisim character and I think she was empowered from her experience with the core group and elders. Throughout the course of this project, she demonstrated that monogamy, condom use, and STI/HIV testing were important to her and she realized how alcohol factors into the high risk lifestyle leading to AIDS. From my perspective, knowledge translation connects to your higher self in a holistic way for the greater good. I believe that she was able to connect to her higher self when she created this play with the ideal solution to the problem. A scenario is below.

After having confessed their infidelity, Kehew and Pisim, two characters in the play, reunite after having had time to think it over. They talk about their drinking. The following is an excerpt from the play.

KEHEW: Will you ever cheat on me again?

PISIM: No. No! I want to quit drinking. That's when all the trouble happens between us, when we're drinking.

KEHEW: Yes I know.

PISIM: Well we can both quit drinking.

KEHEW: That's an idea. Do you think we can?

PISIM: I don't know. We can try.

(They hold hands).

KEHEW: So what does this mean then?

PISIM: I want to stay with you. I don't want to give up.

KEHEW: I don’t want to be with anyone else but you.

(They hug).

KEHEW: I missed you so much.

PISIM: I missed you more.

The co-creators of this story offered hope for young couples and a willingness to overcome challenges in this Northern Alberta community. The story lives only on paper because it was not performed.

Post-theatre discussion.

After each story within “My People’s Blood,” I engaged the audience in a post-theatre discussion. After the Savannah and Buddy story the popular theatre practitioner took notes, the co-researcher/actors prepared for the next scene, and I asked my first question. After my first question, nobody said anything. I was not sure if this was because of the nature of the question, their awe with the performance or shyness to speak up. Then I went to the second question and they responded. Asking the audience questions involved thinking on one’s feet like a talk show host and responding to what the audience was saying rather than adhering only to the set of questions I had prepared, in other words going with the flow. The questions are below and the community responses are in quotation marks, followed by my comments:

1. So Buddy’s friends and Savannah, his lover, rejected him, do you think that this is an accurate reaction of the community?

   The community audience did not comment.

2. Alice, Buddy’s mother, did not know what to say. What can we do to help parents deal with HIV? What do you think of her idea of having a sharing circle?

The idea of having a sharing circle was not rejected but the community members felt that it was important that the youth have sexual health information available to them. They felt that “parents need resources” in communicating accurate information on this topic. In other words, all parents in the community should have a “basic understanding” of how to talk to young people about HIV. This requires increasing education and improving literacy. In retrospect, I think that teaching parents about communication could happen on a one-to-one basis or in a sharing circle at which time a facilitator could introduce culturally specific information on gender roles. The idea of introducing culturally specific information on gender roles will be explained in Chapter Nine.

I wondered what made communication so difficult between a parent and young person so I asked why it was so hard to communicate to young people. Someone stated that, “it was hard for parents to be open particularly about sex,” and “no one talked to them about sex and their own learning experience of sex happened at school.” As a result, “they still need guidance in this area to help talk to their young person about sexual health.” This response may reflect the intergenerational trauma of an older generation who might have attended the residential school and resulting difficulty in talking about sex across generations. Perhaps the experience of the residential school is the cause of the breakdown of cultural and gender communication. Then someone asked me, “How do you explain this concept to elders?”

At the time, I was not sure how to answer this question beyond acknowledging the need for a person who could translate English to Cree and vice versa. Upon reflection, my response is that translating knowledge in culturally appropriate ways on topics of sexuality, cultural roles and self-respect based on Indigenous values needs to be shared within and across communities. There are rite-of-passage ceremonies practiced amongst Cree people in those areas which have maintained their traditional knowledge more than other areas. This information should be brought into communities and reintroduced for the purpose of developing culturally-appropriate ways of preventing STI/HIV. Older people need guidance to pass on the cultural values to parents and young people so that their role within the community is still valued. Values, along with current health information, should be passed on in these rite-of-passage ceremonies. In order to accomplish this, workshops for elders are needed to update their existing knowledge of sexual health information and cultural teachings.

3. If you were Buddy’s mother, his friend, or his lover, what would you have said to him while he was alive?

After not getting the support and understanding that he needed from his friends and family, Buddy was hurt and alone with his HIV. Watching Buddy crash his car and the events unfold at his funeral, the audience felt the loss. His friends stated their feelings at his grave. It was not surprising that an audience member would state that, “it is important to acknowledge these feelings when the person is alive and to let him know how he affects others so that he knows how important he is, as a person.”

I also wondered how we could get the STI/HIV prevention information out there to more community members so I asked, what can we do to get the idea out there? One community member identified with the urgency of this issue and commented that “young teenage females are having children and some children as young as eleven years of age are sexually active.” In response, a community member stated that, “there should be more performances with information for people to have, and the schools should allow this message to be presented.”

4. Savannah has a bad scare but is HIV negative, how can we prevent someone like her from getting HIV in the future?

Savannah’s character was villainous and miserable in nature. She was prone to volatile outbursts and capable of deceptive flirtation. She had commanded the attention of the audience who wondered if she would test positive for HIV. She was HIV negative but the audience did not get the sense that she was a better person having learned something from the situation. The question prompted a discussion about prevention. A community member stated that, “in order to stay HIV negative it is important to have an honest relationship, respect oneself and others, and a person needs to be aware of how their thoughts, feelings, and actions affect other people,” and “by being self-aware one can have self-esteem.”

Sensing that self-esteem was an important topic, I wanted the audience members to provide their own answers on how one develops self-esteem. Some of the answers included, “you get it by being with positive people and with people who care” and “self-esteem is something that you have to earn.” In addition, “parents have an important role in developing a child’s self-esteem; by giving affection, praising, and encouraging a child,” a child will develop self-esteem.

A parent commented on the increased level of maturity among children in physical appearance and how they seem to take more risks now than in the olden days. One female parent stated that ten and eleven year-olds are more “adventurous” today and it seems that “their bodies are going through physical changes earlier” so “how do you explain HIV to a mature and adventurous child?” This same parent stated that “children think condoms are only to prevent pregnancy.” Parents know that there are gaps in young peoples’ knowledge about safe sex practices but they may fear that by talking about safe sex they are encouraging the young people to be sexually active contrary to their intent. Since parents find the communication of sexual health information to their children difficult, it seems that parents need additional resources to inform their children about sexual health and knowing when and under what circumstances it is appropriate or right to be sexually active. With added resources, parents can play an important role in their adolescent’s personal development. Young people will not only receive sexual health education in schools they could also get a more personal approach offered from home.

The post-theatre discussion was not just a question/answer period. It was an opportunity for community members to engage in a sexual health discourse with one another. It was a dialogue based on compassion. They shared their own knowledge and opinions in a respectful way with one another and in a way that was respectful of the topic. Having this type of discussion demonstrates how community members can help themselves and provide answers for one another if there are venues for them to do so. These venues foster community capacity building.

Then someone else wanted to know what to do when someone discloses being HIV+ because people are afraid. Another community member offered an answer, saying that “those living with HIV need reassurance of their own humanity - that they are a person not a disease.” When a person thinks they have done something wrong or have something wrong with their bodies, they feel worthless and they may even want to die. So, telling people they are not a disease but a worthwhile, loveable, important human being goes a long way towards that person’s acceptance of their disease and toward acceptance and understanding of them by others.

After presenting “Alix’s Story,” I repeated the process and asked the audience members questions while the popular theatre practitioner took notes on flip-chart paper. I also invited the co-researchers/actors onto the stage. The audience members then asked an important question to the co-researchers/actors.

In the closing part of Alix's Story, Alix asks the community members/audience if anyone would be interested in attending a conference. In this way, Alix bridges the fictional drama to the reality of the audience and the community. This allowed the researcher to focus audience attention to a sign-up sheet by the door and to continue on with the momentum from the play. On the roll of paper by the door the audience members wrote messages of encouragement to continue with the process and one person[67] provided a phone number. I then asked the following questions:

5. What would it take for someone with HIV to become a public spokesperson for the community?

The community responses were, "it would take courage, a lot of heart, support, and more understanding and acceptance from the community." In response to this comment, by using the Indigenous Iterative Webbed Circle and the values of kindness, honesty, caring, and strength to speak to or about infants/children, teenagers, adults, and elders, the comments from the community members show how they demonstrated compassionate for their fellow human beings. Through compassion and understanding, acceptance can develop. Even though approximately two hundred people attended the event and the local media followed the story reaching more people, I believe that until stigmatization is nonexistent and prevention completely effective, more community awareness is needed. Although obtaining acceptance and understanding for people living with HIV seems like an insurmountable task for many reasons, people with sexually transmitted diseases like HIV need to be encouraged to speak out and not be afraid of being judged for having a preventable sexually transmitted disease. There will always be others who are judgmental and will take the moral high ground. Maybe it is impossible to engage everyone to work towards our survival as peoples.

This STI/HIV prevention project used popular theatre and action research in an Indigenous community and I wanted to know if the community members could identify action points as they explored this community health issue.

6. Where in the story could someone have intervened to stop someone like Alix from getting HIV?

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[67] An attempt was made to contact this person at a later date but this person was unavailable to become involved due to previous commitments.

The community members agreed that, “her friends should not have abandoned her” because it left her vulnerable to the rape. A community member also emphasized the important role of educators at the junior high school or middle school level in providing sexual health and safety education. With the consent of parents, if educators talked about risky situations with students, students could learn about prevention in terms of “knowing what to do and what not to do.” Educators might discuss with students the benefits of abstaining from both alcohol and sex and of avoiding high-risk situations just as they discuss abstaining from drinking and driving or “getting into stranger’s vehicles.”

A related question I asked them was to identify how to move towards social and community action by identifying key action points, I asked:

7. As a member of Alix’s family, what would you say or do?

The community members answered the question from a place of compassion and understanding for a person living with HIV. They said they wanted to “provide support and understanding.” They stated they would “empathize with her and reassure her that she is not alone.” They wanted to “be a good listener.” They wanted to “demonstrate they are not afraid of the disease” and they wanted to be able to demonstrate love and affection through “hugs and kisses.” They did not want to alienate the person living with HIV by giving into fear-based thoughts that they could catch the disease if they hugged them. Lastly, they also realized that it is important for supporters to “understand the emotional issues of HIV/AIDS.”

Through popular theatre a community member watches another community member perform on a social/health issue that is affecting the community. The viewer relates to the characters and the topic. Discussing the performance through a post-theatre discussion allows community members a chance to share their thoughts and reactions to the story, learn from one another’s comments, and identify action points from which solutions can be drawn to prevent unfortunate situations. The action points serve to create solutions in the abstract world of the theatre that can be applied to the concrete world. The method of presenting health information through theatre followed by a post-theatre discussion was beneficial for the community members who attended the performance.

8. Does the community need sharing circles? Would community members attend?

The community members were in favour of sharing circles but were reluctant to participate because "they would be concerned about what others think because people may think that they have HIV." Even though we had finished eating and had watched the play and felt safely protected in a cocoon where we could talk about our social and health concerns, outside the tempestuous storm winds blew. Those of us inside realized that outside of our cocoon there was still a stigma associated with STI/HIV.

9. Was using theatre a good way of presenting the STI/HIV topic?

The health information presented in these two stories was received enthusiastically. One person stated, "It was totally awesome to see this presented in this community!" Another community member agreed and added that theatre "is appropriate for all youth issues and it would be helpful to have it in Cree."

The audience members also had an opportunity to ask the co-researchers/actors questions. They were asked if being involved in this project increased their knowledge or changed their opinions about sexual health. Rocky responded: "I learned lots. I have safer sex, and this is a new beginning." He also discussed how emotional it was for him to test for STI/HIV and how relieved he was afterward. This process empowered the group members to become advocates for STI/HIV prevention and testing.

10. For the future, is there anything more that the organizers can do to improve the way STI/HIV information is presented in theatre?

Overall, everyone was pleased with the event and one member asked if this project could continue. Although this part of the project was over and Jane Heather was leaving the community, there was still more work required and I planned to follow-up on one Elder's suggestion to have a conference where health care professionals, people living with HIV, community people, and leaders could respond to this health issue. I saw this as a spin-off of the action research cycle towards community action and advocacy.

In summary, the performance and post-theatre discussion with the community members are examples of knowledge translation and knowledge exchange. The core group members who developed and performed their stories for the community connected to their higher selves and shared the best of themselves with the community by engaging in a discussion about STI/HIV. Those who created a story but did not perform it made a connection to their higher selves without sharing that with the community. Knowledge translation and knowledge exchange are helpful for making effective social and health change. Popular theatre and action research were helpful for addressing issues around abuse, addictions, and STI/HIV transmission. Popular theatre stimulated the discussion and knowledge exchange. The evening was more than a night of entertainment, it was a community coming together to view a play and discuss authentic situations through the presentation of characters and a fictitious plot. Popular theatre and action research helped the co-researchers understand the cyclical pattern of unhealthy behaviours that lead to STI/HIV that stem from learned behaviours across generations. These methods helped begin a decolonizing process that should be ongoing and far-reaching.

Chapter Nine: Conclusion

My interest in sexual health began years ago when HIV emerged and it seemed absurd that people could die from having an intimate sexual relationship with another person when one of the purposes of sex is to create life. Sexuality within Aboriginal communities has been adversely affected by Church and state. At the start of this research project my assumptions were that Aboriginal sexuality was influenced by political, historical, cultural, psychological, and social factors. I considered popular theatre and action research as helpful methods towards addressing STI/HIV prevention. The methods encouraged the group to give voice to these issues, create a play, and present it to their community members so everyone could discuss it publicly.

The sources of narrative data obtained from field notes, sharing circles, journals, and interviews illustrated the difficulty of conducting STI/HIV prevention research in a community that, for the most part, has been ignoring HIV/AIDS. In this context the real stories of the young people are juxtaposed with the fictional stories contained in the play "My People's Blood." The stories are snapshots.

We have a long way to go to reclaim our Indigenous identity. Many Aboriginal people are still affected by childhood abuses after having experienced intergenerational trauma. The real and fictional stories that were told reflect the knowledge, behaviour, and attitudes of young people. One theme that surfaced was that young people are "numbing out" on alcohol and drugs in an environment exposed to HIV. It is a deadly cocktail for infection and implies a population decline.

The popular theatre and action research processes helped the group give voice to many experiences that were subsequently fictionalized and performed. With honesty, the truth about the spread of STI/HIV emerges through the stories told by the young people from their perspective. The play and the post-theatre discussion are symbolic representations of a community coming to terms with this disease. The public performance put this rather taboo topic front and center and brought it out in the open. Community members examined the modes of STI/HIV transmission as seen through the eyes of its young people participating in the public performance.

Through the introduction of both Grandmother Spider and the Indigenous Iterative Webbed Circle, I was able to analyze the process and stories. Using this model I wove in and out of the personal stories, plays, and the relationships of those who created the stories, along with those who watched the play. This method allowed me to meet the challenge of connecting the fictional stories and participants' realities in relation to the subject matter.

Throughout this research project and in the analysis, I wanted to know if popular theatre was a culturally appropriate medium for Aboriginal people to increase knowledge of STI/HIV. Secondly, I wanted to know if these methods would enable the audience members to express their attitudes, knowledge, and behaviours related to sexual health. I wanted to know if popular theatre and action research could help prevent STI/HIV. And, I wanted to know how the participation of the elders and popular theatre practitioner would influence the intervention. Lastly, I wanted to know if action research and popular theatre influence the attitudes, knowledge, and behaviour in a way that promotes healthy sexual choices.

Before I entered the field to begin my quest, I sought solace and comfort through ceremony. I garnered strength through the prayers of elders as I began the process of retracing my steps from Hobbema, back home to Northern Alberta. Although the elders were an intrinsic part of this journey I received a tremendous amount of support from other people and organizations. The support I received was like sweetgrass intertwined into a braid. I had support of community leaders, university professors and the Aboriginal Health Strategy.

The methods of popular theatre and action research helped increase knowledge about STI/HIV among Indigenous people. Theoretically, popular theatre is theatre for the people developed by the people and this coincides with the oral tradition and egalitarianism of Indigenous peoples. In theory, participatory action research begins by involving the residents of an affected community in the research from the beginning because they have something at stake (Adelman, 1993, p. 14). Critical action research is viewed as a process for changing consciousness about "the destructive impact of systems on lifeworlds" (Outhwaite, 1994, p. 92). In this research I invited my community members to be involved in the research project to address the historical, cultural, political, sociological and psychological factors[68] for improving sexual health and preventing STI/HIV.

I have resolved that the methods are not culturally appropriate if the voice of the colonized is not fully vocalized. I refer to a conversation between the popular theatre practitioner and myself. After she told me that my voice was too dominating, I retreated into the background to observe and collect data, I should have resisted. Community-based participatory research is supposed to be a "cooperative" whereby community members and researchers contribute "equally" (Minkler & Wallerstein, 2003, p. 5). In my self-reflection, this "passive" stance might be due to internalized colonialism whereby I discounted my own right to help solve my community's problems (Brant-Castellano, 1986, p. 52). Through the local newsletter, the group advertised that we were going to produce a play so the push was on to produce one. There should have been more of a balance between the "process-facilitating role" and the "product-producing role" (Stoecker, 2003, p. 100). In retrospect, if I voiced more of my questions I might have prompted more critical thinking from the perspective of a community member and researcher. Potentially, the stories might have focused more on the historical, political and cultural factors that have influenced the sexual health of Indigenous people within my community. Including elders and their teachings and ceremonies does not go far enough to ensure a process is considered culturally appropriate. In order to be so, the voice of the insider researcher is as important as those of the co-researchers in the development of the stories.

Among the youth who participated in this project it was evident that the project influenced their attitudes, knowledge and behaviour, whereby they made healthier sexual choices to prevent STI/HIV. The group invited a local Aboriginal nurse to discuss the signs and symptoms of HIV, proper testing of the virus, and preventing the spread of HIV/AIDS. An elder was also invited to discuss holistic health using the teaching symbols of sweetgrass and the medicine wheel as means of finding balance and harmony. These two important speakers were part of the knowledge translation process whereby the co-researchers'

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[68] These factors underpin the social determinants of health.

attitudes, knowledge and behaviours began to change. Although STI/HIV testing was not part of my original proposal, as a result of this research project the group made a collective decision to get tested for STI/HIV and keep their results private and confidential. The reason for collective testing was to provide support to one another, as the group was aware of the stigma of HIV/AIDS. In their journals, talking circles, and one-to-one interviews, the youth discussed the impact of waiting for their results. In addition to testing for STI/HIV, group members mentioned consistent condom use, maintaining a monogamous relationship, expressing a desire to not use alcohol and drugs, and talking to their friends about STI/HIV prevention. The process was empowering for the participants and being involved helped to develop their capacity at becoming advocates of STI/HIV prevention.

Beyond the parameters of our group, the project had an impact on the community and this was evident through the feedback we received. During our group meetings the co-researchers would share the feedback they received from their family and community members. Family members encouraged them to be involved and community members expressed curiosity about the project. Community members helped with several elements of the event. Unfortunately, there is not enough data to establish the level of impact the project had on the community.

The group members wanted to dispel the fear their community members had about STI/HIV because this was leading to the stigma of AIDS. The local media reported on this project after the group submitted a letter to the editor explaining that their intention, which was to promote social/health change. Presenting HIV statistics in the local media seemed to prompt more fear and more stigma; we lost two group members afterwards although it is not clear what their reason was for resigning. Most original group members stayed with the project to perform and be a part of the solution to preventing STI/HIV – this meant they were local heroes. The group members were recognized for their STI/HIV prevention efforts.

The elders who shared their stories of the residential school era provided feedback to the co-researchers at a rehearsal. In watching the group rehearse, the elders boosted the confidence and morale of the group. At one point their faces were worn with concern as they watched a dramatic scene where a young person disclosed to her kokum[69] that she had AIDS. From my perspective, AIDS is a heinous offence particularly to any kokum or a moshum[70] who has to hear their nosim[71] has AIDS. The Indigenous culture is future oriented. We think seven generations ahead. Another example of the effect the elders had on the group happened during a talking circle. Two women elders could not have expressed their support better than to step forward and hug a young woman in our group who declared that she wanted to be a community spokesperson for STI/HIV prevention.

The impact of the plays is evident in the post-theatre discussion with community members. Community members expressed a need to know how to talk to young people about healthy sexuality and STI/HIV prevention. They stated that they needed more resources to teach the youth and elders about this topic.

Many precipitating factors in the spread of STI/HIV came to the foreground. The factors leading to STI/HIV are associated with alcohol, drugs, sexual promiscuity, ethnicity and gender. To be able to stop misusing drugs and alcohol requires an urgent desire to stop, and a supportive program or group to help the user to stop using. As one group member stated, people become addicted “when they feel like there is no point.” Being stigmatized by having HIV shames a person into submission to the point where “you don’t care.” This attitude prevents people from seeking knowledge about HIV or changing their behaviours related to healthy sexuality and STI/HIV prevention.

Racism, discrimination, and stigmatization are factors that lead to attitudes that precipitate addiction and infection. Mainstream society is not aware of the full effect that colonialism has had on the identity of Indigenous people. Native American community based health practitioners and consumers are identifying historical trauma as an example of “counterhegemonic theory” (Chavez, Duran, Baker, Avila & Wallerstein, 2003, p. 86). Had the popular theatre practitioner been of Indigenous ancestry these stories of historical trauma might have been further developed. An Indigenous popular theatre practitioner might

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[69] In Cree: grandmother

[70] Grandfather.

[71] Grandchild.

have been able to extrapolate these stories from the lived experiences of Indigenous youth by being able to relate to their experience, first-hand. Researchers state that:

> Community based participatory researchers working in communities of color, and particularly in native communities, would be well advised to be conversant with historical trauma and related theories. The advantage of engaging with such approaches is that they speak directly to the lived experience of individuals and groups and may therefore be more widely accepted as the basis for research and intervention emanating from the community (Chavez et al., 2003, p. 86).

I would add that popular theatre practitioners working with community based participatory researchers ought to be conversant with historical trauma too. Like Grandmother Spider who uses all of her silken weave to create a web, the story must be developed linking all parts to the whole. As a non-Aboriginal it seems that she did not press that connection.

At one point during the process, a group member reminded me that the popular theatre practitioner was my “guest” into the community. Based on this comment and in retrospect, I perceived that maybe kindness or a reluctance to confront the white popular theatre practitioner was overshadowing honesty. Normally, politeness is not an undesirable attribute, but when you are trying to critique the lived experience across time and space, exercising politeness or holding back can prevent critical thought. Scorning the dominant society with youthful angst might have prompted critical reflections of the political, social, historical, cultural and psychological consequences, of intergenerational trauma stemming from the residential school. Understanding unhealed intergenerational trauma helps the present generation understand what has happened to their people across time and space. In Alix’s Story the group drew upon intergenerational trauma but not to the point of identifying the historic roots. The historic was not made explicit. This would have enabled the community members to give voice to their shared history in a public venue. Perhaps the community members would have been able to identify and empathize with those who “numb out” on alcohol and drugs in an environment where HIV lurks.

Research is supposed to lead to findings and given the exploratory scope of action research and popular theatre what I found was that having a popular theatre practitioner who does not share the same political, cultural, historical, sociological and perhaps psychological background, altered the fictionalized stories. Race, gender, and history impact the real lived experiences and fictional stories of sexuality among Indigenous people in Canada. If I had an Indigenous popular theatre practitioner this would have impacted the storyline but to what degree I do not know. If I resisted the popular theatre practitioner's request to let others speak, I might have been able to add a further critical element to the action research and popular theatre process.

For non-Aboriginal people working with First Nations and Métis peoples, who have experienced oppression and colonization, the non-Aboriginal role is to encourage self-reflection and critical inquiry by way of example. The non-Aboriginal role is to acknowledge the effects of colonization on First Nations and Métis through a self-reflective and critical perspective. By critiquing the broader determinants of health, First Nations and Métis move towards decolonization.

I would have liked to have viewed a story about Indigenous peoples who have conquered the effects of sexual abuse to regain a sense of healthy sexuality through a culturally appropriate practice. Instead the stories that were developed are a reflection of where the community is at minus the discussion of historical trauma. Given that the community was in a stage of decolonization visible through the demolition of the residential school and stories reported in the local media, I would hedge that the community was ready for that discussion given that the Chief led the historical discussion by discussing the epidemiology of infectious diseases among Indigenous people in Canada.

In the post-mortem following the public performance, community members might have identified the need for healing the intergenerational effects of historic trauma as possible answers for STI/HIV prevention that specifically identify re-learning about land, language and cultural ceremonies. Those possible solutions might have emerged if my voice as the researcher was heard during the story development phase. My voice reflects that of a mature Indigenous women who is educated, well-connected to the elders, articulate, and sensitive to the issues of historical trauma, whereas the youth who were involved in this project were living examples of the proof of historical trauma and unable to articulate it because they did not have my level of education, experiences and maturity. As suggested by my co-supervisor, it is because of my tenacity and commitment that this project happened at all. I would add that it is because of my belief in Natural Law whereby spirits help humans to manifest social/health change. We as Indigenous people are all re-learning to be Indian and it is a life-long process, as Blackfoot scholar Narcisse Blood has said (personal communication). Learning to be Indian is an experiential process whereby we learn through doing and it becomes part of who we are.

Other solutions to encourage critical thinking would have involved maintaining the proposed length of this project, instead at sixteen weeks, instead of reducing it to a ten week project and including the elders more often. Keeping the original plan would have enabled more time for the group to spend with the elders who are our historians and knowledge keepers.

Instead of using all that rich cultural history, the young people reached within their own lived experience and developed a play that identified alcohol and drugs as factors leading to HIV/AIDS, among young Indigenous people. Also contained within the play were messages about single-parenting and the subsequent negative impact on children growing up in a fatherless home or in an environment where drugs and alcohol abound, thus putting children at-risk. There was a disconnection in the background story of all these gut-wrenching case scenarios again because the historic was not made explicit.

Grandmother Spider, a true creatrix who watches and warns others about the ramifications of the excess use of alcohol, drugs, and casual unprotected sexual encounters watched silently wondering if the group was going to nail the prevention effort on the head. I acknowledge Grandmother Spider as a spiritual entity from other tribes. She has helped me develop a model and write from the margins on this popular theatre and action research project that addresses the sensitive subject of STI/HIV prevention in an Indigenous community, impacted by historical trauma and colonization.

A lesson to be learned from this exercise is to train and hire an Aboriginal popular theatre practitioner who has shared the same experiences as the group they work with so they can prompt critical questions that reflect the intergenerational phenomena of abuse that stems from the well-documented assimilation efforts of Church and state. In retrospect, I should have used my experienced voice more if I wanted the group to develop a play based on the historical impacts, but I pulled back my enthusiasm and retreated into the quiet landscape of the researcher. Paradoxically, the popular theatre practitioner's words have allowed me to find my voice in the margins of what would have been, could have been, and should have been. In so doing, it allows me to speak about colonization and its impact on Indigenous people and the action research spiral continues.

Following this line of reasoning, I resolve that action research and popular theatre are methodologically appropriate mediums for STI/HIV prevention in that they enabled the group and audience to give voice to sensitive issues in a public forum. Through the community performance it was evident that the venue of the stage is a place where the sacred world can fictionalize a reality whereby young Indigenous people can portray characters and present issues surrounding a topic as sensitive as STI/HIV.

Popular theatre and action research bring a community's stories to the stage. The performance gave the community members reasons to be proud of their young people. After the lights went up the applause was encouraging and supportive. The post-theatre discussion which followed allowed the group members to translate their experiences, and allowed the wider community and the group to exchange this knowledge further. Prior to this post-theatre group discussion, the community had been silent on the topic of STI/HIV transmission but that night was one to remember as elders, leaders, parents, and young people demonstrated their compassion and concern towards those living with HIV with kindness, honesty, caring and strength. With their support, the co-researchers disclosed that they tested for STI/HIV. They would not have done this if they did not feel a shift in community attitude towards one of support and acceptance. What was perceived as a socially stigmatizing disease became less so as people's hearts softened to the issues presented in the play, "My People's Blood."

Despite this lingering good hearted spirit that consoled, nurtured and protected the group that night, a stern and foreboding message remained as delivered through the play, "My People's Blood." One, raise your children in a healthy way. Two, stop misusing alcohol and drugs. Three, work out your relationship problems. Four, practice safe sex. Lastly, accept those people living with HIV. After all, we are all connected – All My Relations.

Lessons Learned

If I had to do this over again…if I was to provide suggestions to others wanting to work with Aboriginal people in Canada using popular theatre, I would provide guidance based on my own valuable learning experiences. Lesson one: Hire a Native popular theatre practitioner who has experienced the same lived experiences as the group, to enable the researcher to fully focus on the research component. The person ought to have similar historical, political, cultural and social experiences as the participants. Lesson two: If hiring a non-Native popular theatre practitioner, make sure that the historical, sociological, political, cultural, and psychological factors are thoroughly addressed by the group members. This may mean that young people should spend more time with their elders and knowledge keepers to discuss history, the social background and politics impacting the community, cultural teachings, and the affects of historical trauma on the mind, body, and spirit. Lesson three: Review the concepts of action research and popular theatre so that the critical voice towards story development is included and respected. The critical questions should be developed by both the popular theatre practitioner and researcher before emerging in the field, with periodic reviews in the field and a process in place to reach agreement. Lesson four: Lengthen the course of the project beyond ten weeks and include more time for the young people to be with their elders so they can learn about their history, culture, land and language; the elders' presence will help the group deal with conflict. Lesson five: Understand and use the values of kindness, honesty, caring and strength as guiding principles for the group process. Lesson six: Reiterate these principles for the benefit of all group members throughout the project. Lesson seven: Use the Indigenous Iterative Webbed Circle as a guide for analyzing the results in order to connect the layers of stories that are shared. Lesson eight: Use the Indigenous Iterative Webbed Circle to connect the lived realities and fictionalized stories for health promotion and disease prevention in a culturally appropriate way. An example of this is using the rites of passage ceremony at a time when young Indigenous adolescents learn their cultural roles with respect to their gender. During those ceremonies older women and men could speak to the young people about sex being sacred and preventing STI/HIV. It is in those moments where prevention and health promotion from an Indigenous perspective can be applied.

Having stated the difficult lessons that I learned from this project, I would like to conclude by stating that these methods require all participants to have a stubborn determination, unwavering faith, compassion for community and a desire to contribute to the greater good of humanity. While these virtues are vital, I would like to add that it also requires funding - Alberta Health Strategy. Providing meals, honorariums, and hiring people to help with the production countered the socio-economic difficulties that young people, families, and elders experience. Having the funding enabled me as a researcher to follow cultural protocol and invite the elders to participate. The funding enabled the young people to connect with their elders and learn about the experiences of the older generation as well as learn about cultural beliefs and ceremonies. The Aboriginal Health Strategy provided funding that empowered the group to address STI/HIV prevention using popular theatre and action research in an Indigenous community and with Grandmother Spider they wove stories to create the play, “My People’s Blood.” Lastly, a community came together to discuss the sexual health of their community with an open spirit and in that way, this project helped to reduce the stigma of STI/HIV. As a result, there is hope for future generations.

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APPENDIX A: FIRST INTERVIEW QUESTIONS FOR THE GROUP MEMBERS—START OF THE PROJECT

1. Why are you involved in this project?
2. What do you do to feel safe sexually?
3. How do you think your involvement in this project affected you, your family, and the community?
4. Do you think this process will be helpful for addressing STD/HIV? If so, how?

APPENDIX B: SECOND INTERVIEW QUESTIONS FOR THE GROUP MEMBERS - MIDDLE OF THE PROJECT

1. How is the project going?
2. Since starting this project what have you done to feel safe sexually?
3. Since starting this project how has your involvement in this project affected you, your family, and the community?
4. Has the process been helpful for addressing STD/HIV? If so, how?

APPENDIX C: INTERVIEW QUESTIONS FOR THE GROUP MEMBERS—END OF THE PROJECT

1. Why are you involved in this project?
2. What do you do to feel safe sexually?
3. How do you think your involvement in this project affected you, your family, and the community?
4. Do you think this process will be helpful for addressing STD/HIV? If so, how?

APPENDIX D: BARRIERS TO SAFER SEX, ABSTINENCE, AND MONOGAMY

Barriers to safer sex	Barriers to abstinence	Barriers to monogamy
Hard to talk about penises, vaginas, sex generally	Too turned on	Alcohol/addictions
Low self esteem	Arousal	Lack of communication
Bitterness: I have this so everybody else is going to too.	Feels good	People get fed up
Addiction (the group shifted to barriers to treatment, disclosure, testing)	Chemistry	Boundaries; pressure from the past
Feeling judged	Sexual abuse, person become sexualized and then sexually active	Stalking
Family is ashamed	Love	Partner not interested in sex
Denial	Scared of commitment	Revenge: you get mad, go out and go to bed with someone else to punish partner
Scared to be shunned or pushed away	Got drunk	
Don’t want to embarrass family	Tired of masturbating	
	Rape	
	I just want to try it	
	Peer pressure	
	Nobody told me not to	
	I want to feel grown up	
	I want to get it over with	

APPENDIX E: REASONS FOR SEVERAL SEXUAL PARTNERS

Responses for females	Responses for males
Low self-esteem	Being the man
Self-hate	I want to be loved
Despair	Fun
Peer pressure	Because they can
Needing power	It's like a game
Feeling like they can't do better	It's like hunting
To feel loved	It's all about me
It's my job (sex trade workers)	Competition (to get laid the most)
Nymphomania	Set the bar high and be the best she's ever had
It's cool	I'm good in bed, I want to share
	It's my job (sex trade worker)

APPENDIX F: GRAFFITI WALL

WHAT PEOPLE THINK ABOUT STI/HIV

1. “The almighty powerful sexual woman or man rules the world. Yeah right!”
2. “Women have it worse than men, rags, periods, and babies.”
3. “Yeah, but do men know how to love?”
4. “How come women are not taking control of their bodies?” Someone responded “[There is] no one else to love them. Peer pressure, sell their self short. They think they can’t do better.”
5. “Men cheat more because they can’t get pregnant.”
6. “It’s been seven years since I’ve had HIV. I still want to be loved. Is there anyone with HIV who I could love? And could still love me? Please help me I’m so alone.”
7. “Don’t cheat.”
8. “Why do women cheat all the time?”
9. “Sluts!”
10. “Lick the dick.”
11. “Respect a woman’s body.”
12. “So what does that mean?”
13. “Women bring life into this world. Don’t touch unless asked.”
14. “If you’re not with somebody, does that mean you’re nobody?”
15. “There is always a diamond in the dirt?”
16. “Nobody else will love me.”
17. “My boyfriend isn’t abusive he’s just like that when he’s drunk.”
18. “My brother died of AIDS because he had HIV.”
19. “If nobody hits on me does it mean I’m ugly?”
20. “Look in the mirror and say one nice thing to yourself ten times.”
21. “Sex is just something that everyone is doing.”
22. “If I had one STD, could I get HIV too?”
23. “I’m too shy to buy condoms.”

24. “I didn’t know HIV was the same as AIDS.”

25. “I have no money to buy protection one dollar is just too much!”

26. “Don’t go with a gay guy he’ll give you a disease.”

27. “Come on! It’s not a gay person’s disease. Men, women, and young people are getting it.”

28. “Whoever started this disease is a horny bastard! Damn you!”

29. “But what if it was your family member who brought this disease here?”

30. “After hearing about all those diseases I am scared to even sleep with anyone!”

31. “I don’t care I am not going to get it.”

32. “Well then you must not care about a lot of things.”

33. “What would you do if you passed STD/HIV to someone?”

34. “Don’t forget to wear your rubbers.”

35. “Little Mexican hats can save your life.”

36. “Thank God I am a horse and I don’t have to worry about HIV or STDs, those poor humans.”

APPENDIX G: GRAFFITI WALL OF AIDS

Positive Messages/Images:

1. A feather was drawn and the words “power of hope,” written beside it.
2. Stars and five drawn fists are drawn together in a symbol of unity with the words “power to the people” beneath it.
3. Colourful flowers with words “flower power” sprout up.
4. Colours are drawn into a medicine wheel.

Neutral Messages/Images:

1. A yin/yang symbol is drawn.
2. A formée cross is drawn perhaps to depict the official announcement and marshalling of combatants in the battle of lives for the prevention of STI/HIV against the opposing forces.

Negative Messages/Images:

1. A swastika with bricks of peoples’ heads on top on top of the bricks,
2. Crosses depicting the death toll of the disease, the words “evil lives” reign. Beside it are alcohol bottles and a penis with sores.
3. Cannabis and dollar signs are drawn with the words “power of drugs” and “power of money.”
4. Devil’s blood fills a human body while darkness shadows a haunted face.
5. A lightning bolt strikes a person dead with a voice laughing, “ha-ha.”

APPENDIX H: ALIX'S FRIENDS

Name	Character	Sexually Abused	Alcohol/Drug User
Alix	16 years old female who goes to school. She is a virgin. She was inappropriately touched as a child.	Yes	Uses drugs and alcohol
Alexis	17 year old female who hides her inner feelings behind alcohol and drugs.	Yes	Alcohol and drugs
Sahara	15 year old female and is one of Alix's closest friends. She likes parties and has no steady boyfriend.		Possible user of alcohol and drugs at parties
Gus	He grew up with Alix and was involved in a car accident and he is now in a wheel chair.		Alcohol and pills
Shanaya	She is a constant drug user. Likes to go to raves. She is outgoing. Hates school. Young people look up to her because of her personality.		Has tried every drug there and prefers ecstasy
Frank	He is a bully. He likes to pressure friends to drink, steal and lie. He feels lost.		Drug user
Buddy	He is 19 years old. He likes to chill out, smoke weed, play basketball. He has an abusive father. Buddy tried to commit suicide once.		Cannabis
Oreo	Alix's cat		

APPENDIX I: ALIX'S FAMILY MEMBERS

Name	Character
Virginia	Alix's mother is a mental health counsellor. She is miserable with her husband. She is unhappy in her community. She cannot even counsel her own children.
Chuck	Alix's dad lives on welfare. He lost his arm in drug deals to gangsters and drug dealers. He is constantly in and out of jail.
Wilma	Alix's older sister is 20 years old. She goes to college and visits the community once a year. She has no boyfriend. She has no time for one. She is determined to become a nurse.
Cousin Sue	She is 21 years old. She is single but has someone she sees who is on the road a lot. Sue has no children. She is quite stable considering how she grew up. Sue is Chuck's niece.
Kokum	Alix's kokum plays bingo and does bead work. She was married for 25 years until her husband died.
Moshum	Deceased and died three years ago but his memory lives.
Little Timmy	He is a 16 month old orphan who lives with Alix's family. His mother died in a car accident and his father is in jail because he drove over Timmy's mom.
Rusty	Rusty is a golden retriever. He has been the family pet for ten years. He loves Alix.