ka pamihiwehk mino pimatisiwin: kichi ininiw ahkosowinow kakiskaocik ahkosowinow HIV: (Promoting mino pimatisiwin: Urban Aboriginal Women Living with HIV)

by

paskwawimistos iskwew (Buffalo Woman)

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Abstract

This research project examines the impact of HIV among urban Aboriginal women living with HIV in Winnipeg, Manitoba, Canada. Despite the antiretroviral treatments and HIV prevention strategies, new HIV-positive cases for urban Aboriginal women are increasing. Previous studies have failed to address the disparities of urban Aboriginal women living with HIV. Attempting to understand the lived experiences of urban Aboriginal women who live with HIV, Indigenous methodologies, storytelling, and talking circles were used for data collection. Incorporating the natural law of respect, the women in this project are acknowledged as the experts or knowledge keepers of HIV.

This research project is a way of reclaiming traditional knowledge. To reclaim our traditions, we need to decolonize ourselves, our thoughts of where we came from, who we are, and where we are going. Stating our identity, we empower ourselves as women, mothers, and grandmothers to pick up our medicine bundles. In doing this, we establish our traditional responsibilities as iskewewak (women) in caring for our people through the achimo of the seven sacred teachings.

This research project is like digging up our ancestral roots of knowledge or reclaiming our achimowak (stories), ka is kiskenitaman (ways of knowing), ka is totaman (ways of doing), ekwa ka is itastasiwin (and ways of being). We are the agents of change, the shapeshifters creating a paradigm shift in research. This is my medicine story for urban Aboriginal women. eskonsi.

naskwewasihyowina (Acknowledgements)

I acknowledge that I am living on Treaty One territory, the traditional territory of the Anishinaabe, Cree, Oji-Cree, Dakota, and Dene peoples, and on the homeland of the Metis Nation. I say kinanaskomitin (thank you) to kisemanitou (Creator), for without my spiritual beliefs and ceremonies, this entire journey would not be possible.

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Dedication

This thesis is dedicated to all the women (grandmothers, mothers, daughters, aunts, sisters, nieces, and friends) who have gone on to the spirit world, opening a trail for women who have been affected by HIV. This work is also dedicated to the women who live with HIV today, as you are the knowledge keepers of life with HIV. I hope and pray that our ancestors guide us as we travel together, this unknown territory during this research journey.

I dedicate the following words to the women who graciously shared their stories with me.

> To fail to understand another person's life story is, in general, to reject one's own humanity…For those, who are bearers of a tradition, the opportunity to tell their story can be a gift. Reassurance that they are indeed still alive, that their voices will be heard, and that their cultures can survive. It is a gift of equal importance for those generations to come who will take up that tradition and shape it to their own needs as the future unfolds.
>
> L. L. Langness and Gelya Frank. Lives: Anthropological Approach to Biography (p. 28).

List of Abbreviations

FNIGC	First Nations Information Government Committee
IRS	Indian residential school
NCCAH	National Collaboration Center for Aboriginal Health
NCCHC	Nine Circles Community Health Center
UNDRIP	United Nations Declaration on the Rights of Indigenous People

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Chapter peyak (one)

Introduction

Beginning a Research Journey with a Dream

I begin this research journey by sharing a dream I had in 1998 while working as a community health nurse in my home community of Fisher River Cree Nation. You may ask why? What is the connection with this project? You will understand as you continue reading.

In my dream, I am walking down a street in Winnipeg looking for a particular place. I did not know what this place was or why I was going there. It was cold, blowing snow, visibility was poor. Across the street, I saw a huge brown building that looked like a church. Thinking to myself, I should go into this building to ask for direction. I entered the building to find three women standing nearby. I asked for directions. A lady of colour answered me, "keep walking the same direction you were going, a little over a block, you will find this place." I stepped outside, the sun shining, green grass growing, and flowers blooming. I was in awe because it had been blowing snow only two minutes ago. I continued walking, and a little over a block away, I saw a long white building with a flat roof; over the back door was flying a rainbow-coloured flag. I still did not know what this place was or why I was to go there. My dream ended as I was looking at this building.

In 2000, I accepted a position as an HIV nurse clinician at Nine Circles Community Health Center. One afternoon, in 2002, driving down Maryland Street on my way to work, I was caught up in a traffic jam at the corner of Portage and Maryland, with cars backed up to St. Matthews Avenue. Sitting in my car, I noticed across the street a big brown building, known as St. Matthews Church. The dream I had came flooding back; this was the brown building in my dream. As traffic started, I counted the blocks from St. Matthews Church to Nine Circles, and it

was just over one block! As a spiritual person, I believe that Creator, which grandmothers give us dreams to guide us in our life journey.

I share this pahwam (dream) as it relates to this research project about Aboriginal women living with HIV. Working at NCCHC for twelve years with people who live with HIV validated the dream. The twelve years at NCCHC were my ka is kiskenitaman (way of knowing), and my ka is totaman (way of doing) in developing my western knowledge of HIV and relational accountability and responsibility to these beautiful women who live with HIV.

Completing the circle, I wove new stories from the lived experiences of these incredibly resilient Aboriginal women by finishing this project. As this journey began with a dream, it became a reality. I, paskwawimistosis iskwew (Buffalo Woman), a Muskego ininimowin iskwew (Swampy Cree woman), researcher/storyteller, using my ancestral Cree storytelling tradition, I have blended the western is kistenitaman (way of knowing) ekwa is ottoman (and way doing) with the Indigenous isikiskenitaman (way of knowing) ekwa totaman (and doing). We (the women in this project and I) have yarned new stories of the urban Aboriginal women as they breathe life into the truth of living with HIV. They give voice to their stories and reclaim their place and power in our society, so the next seven generations will know where these women came from and who they were. In conclusion, I will begin this research story by laying the foundation for it.

This chapter provides the background information for this research project, the research problem, the purpose, and research question, the significance of the research project, operational definitions, and the limitations of the research project.

1.1 Background

This section examines some statistical data of Manitoba women and HIV. I am most

interested in how many urban Aboriginal women have been diagnosed with HIV.

To argue my point of an increasing trend in new HIV cases in urban Aboriginal women, I use evidence collected by Statistics Canada, The Public Health Agency of Canada (2014) report which indicated eighty-seven new HIV-positive cases in Manitoba, sixty-eight percent of the new cases are among individuals who live in Winnipeg, and fifty-two percent of those new cases were among Aboriginal women. There was a five percent increase of HIV in urban Aboriginal women in one year. Public Health Agency of Canada statistics revealed that approximately forty-five percent of new cases occurred among Aboriginal women from 2011-2013, of Manitoba's reported three hundred and eight new HIV cases. Further research is required because since 2016 there has been further increase of new HIV cases occurring among the urban Aboriginal women in Winnipeg.

To further strengthen my argument that new HIV cases are increasing in the urban Aboriginal women in Winnipeg, I again use the evidence taken from Statistics Canada. The Public Health Agency (2016) reports "a total of one hundred and nine new HIV cases in Winnipeg and two out of three females with new HIV infections reported their ethnicity as Aboriginal." (p. 26). Dr. Pierre Plourde (2018), medical officer of health for the Winnipeg Regional Health Authority, describes a "change in attitude about HIV…it is not a death sentence it used to be, and people's sexual behaviours are reflecting that…more risky sexual behaviours occurring in men and women" (para. 4).

Becker (2012) states, "more than 43.0 percent of Canadian Aboriginal population live in the three prairie provinces of which 15.5 percent were from Manitoba" (p. 19). Becker states, **"Manitoba accounted for 36 per cent of cases of which one-third were female most common age category of cases were 18-39 years of age" (ibid:20).**

Thirty percent of urban Aboriginal women in Winnipeg live below the LICO-BT (lower income before tax) of $19,000 a year. This data creates a mental picture of how urban Aboriginal women in Manitoba may be at risk for HIV transmission. The urban Aboriginal women living with HIV and those at risk represent a culturally distinct population whose needs can be challenging.

This information gives us a tiny glimpse of the bigger picture of urban Aboriginal women living with HIV in Winnipeg, Manitoba. As there is an increasing trend of new HIV cases among the urban Aboriginal women in Winnipeg and limited existing literature, the findings from my research project seek to contribute to the literature on Aboriginal women and HIV in Winnipeg, Manitoba.

1.2 Research Problem

One problem is the limited existing research of urban Aboriginal women living with HIV in Winnipeg, Manitoba. However, the statistical data reveal that the incidences of HIV in this population of women are increasing.

Despite the antiretroviral treatments for HIV and HIV prevention strategies, the HIV infection rate for urban Aboriginal women in Manitoba is increasing. The increased incidences of HIV among urban Aboriginal women can be related to an "increased risk of HIV exposure among individuals who use intravenous drugs and unprotected sex" (Duncan 2012 p. 224).

I argue that multiple problems are involved in this situation, stemming from the history of intergenerational trauma, social determinants of health, and poverty. All factors that make Aboriginal women more vulnerable to risk situations and behaviours related to HIV transmission. There is epidemiological research relating to HIV and urban Aboriginal women, but a deficiency in the existing literature in how the effects of historical trauma and colonization

contribute to the increased rate of HIV in urban Aboriginal women and how to address these disparities. Becker (2012); Bingham (2014); Bombay (2014); Duncan (2011); McCall (2011).

1.3 Purpose Statement The purpose of this case study is to explore the lived experiences of Aboriginal women in Winnipeg, Manitoba.

1.4 Research Question and Objectives

The central question for this case study is: what factors contribute to the increased incidences of HIV in urban Aboriginal women? The research objectives of my thesis are: 1) explore the perspectives and lived experiences of the urban Aboriginal women living with HIV 2) to understand the challenges and realities urban Aboriginal women identify living with HIV 3) discuss mino pimatisiwin (a good life) to promote health and wellness.

1.5 Significance of Study

The significance of this case study is essential, as Indigenous knowledge contributes to the existing Western and Indigenous literature related to urban Aboriginal women and HIV. This project benefits HIV researchers in further developing deficiencies that emerge from this project. The findings can guide health educators in developing more culturally appropriate policies in HIV care, awareness, and education for Aboriginal women. The findings from this project will further help improve the physical, emotional, mental, and spiritual aspects of women's lives. The findings can potentially help advocacy groups for urban Aboriginal women living with HIV to lobby Aboriginal leaders to take a more active role in setting HIV health policy. This research project adds to the existing literature in promoting mino pimatisiwin (a good life) for urban Aboriginal women living with HIV. This research project contributes by giving direction and guidance to Indigenous peoples' wants and needs in controlling and maintaining their own health care.

1.6 Operational Definitions

All Cree words are in the N dialect - Muskego ininimow (Swampy Cree)

achimo - story, achimowin - storytelling

mino pimatisiwin - a good life

tahpwewin - humility; taphwihitamewin - honesty; tahpwewin -truth

sakatisiwin – courage; sahkihiwenan - love.

iskwew - woman; iskwewak - women

haart - the combination of several antiretroviral medications used to slow the rate at which HIV makes copies of itself in the human body. A combination of three or more antiretroviral medications is more effective than one or two to treat HIV.

human immunodeficiency virus (HIV) is a retrovirus that can infect humans when the virus connects with tissues, blood causing damage to the human body's immune system.

1.7 Organization of the Thesis

Chapter peyak (one) introduces the research project by providing a background for the central issue, purpose, and research question of the study, highlighting the significance of this project. Chapter neso (two) provides a literature review that discusses what factors contribute to the increase of HIV infections among urban Aboriginal women in Winnipeg and highlights Indigenous research. The body of existing literature selected was from various disciplines, such as nursing, Indigenous studies, psychology, and social work; discussed by themes aligned with this project's research objectives. Chapter nisto (three) provides a discussion on mino pimatisiwin. Chapter neyo (four)) describes the research design, a description of the site and participants, along with inclusive criteria for this project with justification, data collection, and

analysis of the stories shared by the participants selected for this research project. Chapter niyanan (five) provides the findings, discussion, and conclusion of this research project.

Chapter niso (two)

Literature Review

2.1 Introduction

This chapter provides a literature review examining Indigenous research. Included are an overview of Cree worldviews, philosophy, values, and beliefs, and the Cree medicine wheel, including achieving health and well-being through mino pimatisiwin.

This section provides an analysis of existing research related to Aboriginal women. The authors that I chose gave their perspectives on why urban Aboriginal women are more susceptible to HIV transmission. Some of the focal writings made significant contributions to the existing body of knowledge in HIV research and a discussion of how mino pimatisiwin is related to self-determination for the urban Aboriginal women living with HIV.

This section examines significant research published about the problem and the themes that emerged from the existing literature. The first theme is an examination of the factors causing an increase in HIV among urban Aboriginal women. Through the related subtheme, social determinants of health, I explored the associations between the **Social Determinants of Health (SDoH)** and urban Aboriginal women and how the women are affected and the subtheme related to implications of HIV among urban Aboriginal women.

The second theme examined how historical trauma has affected urban Aboriginal women living with HIV. Through the subthemes of colonization and Indian residential schools, I explored the effects among urban Aboriginal women living with HIV. The third theme, promoting mino pimatisiwin (a good life) with subthemes of blended healing methods and Indigenous healing methods, examined different methods of promoting a good life for urban Aboriginal women.

2.2. Indigenous Research

2.2.1 Introduction

This section discusses Indigenous research, Cree worldview, and mino pimatisiwin. This thesis is Indigenous research, and in order to comprehend the meaning of mino pimatisiwin, one needs to understand the Cree worldview.

2.2.2 What is Indigenous research?

I argue that Indigenous research is an ancient body of knowledge that our ancestors developed through their observational skills and shared throughout the generations by oral traditions.

Our ancestors were involved in Indigenous research as they investigated the different relationships of the universe and the earth related to people. Due to respect for the ancestors and their ancient body of knowledge, I use the concept of re-search when referring to contemporary research, as I argue that scholars are re-searching or re-examining Indigenous research and contributing their academic scholarship of research to what our ancestors knew.

Our ancestors' different bodies of knowledge offered an approach to development based on the environment's evolution and the ecosystem. This Indigenous research based on observations enabled our ancestors to be resilient in adapting to their environment for survival.

As a collective, Indigenous scholars can create a paradigm shift in academia where Indigenous and Western scholars can begin to collaborate with research and begin the process of reconciliation throughout the academic world.

As astronaut Glen Armstrong said when he landed on the moon, [it takes] "One small step for mankind." In other words, both Indigenous and Western researchers need to take that one

small step together to form those mutual relationships as we have the same goal; to create new ka is kiskenitaman (ways of knowing)!

According to Smith (1999), "research is not an innocent or distant academic exercise but an activity that has something at stake and that occurs in a set of political and social conditions" (p. 818). McGregor (2018) states the first step in facilitating reconciliation is developing "decolonized methodologies [to get back to] Smith (1999) "basic humanity" (p. 215).

Decolonized research, according to Smith (1999), is where "Indigenous peoples want to tell their own stories…in our own ways, for our purpose" (p. 215). Due to the effects of colonialism, Smith states that, by focusing on decolonization, Indigenous people will remain in reactive mode. To facilitate reconciliation in research, Indigenous research as a process (McGregor (2018) "moves beyond decolonized research to bring forth Indigenous worldviews, epistemologies, ontology's, ethics, values and intellectual traditions" (p. 820). Kovak (2009); Wilson (2008).

I think that before Aboriginal and non-Aboriginal people alike can begin to heal from past historical trauma, we all need to reconcile with ourselves, our families, and our communities. We need to create inner peace within ourselves by learning who we are and from where we have come. We need to build a solid foundation within ourselves before we tackle the reconciliation process of the nation.

2.2.3 enisiwapahtamak Muskego ininiw askiy (Worldviews of Indigenous people)

For the title of this section, "worldviews," I cite Hart (2007) as he states, "there is no one Indigenous worldview" (p. 25). Various Indigenous scholars have given their concept of Indigenous worldview, and they are similar but a bit different. Hart (2002), citing Redfield, states that a "worldview refers to the way the world looks to people looking out" (p. 18).

My understanding of the Indigenous worldview is that it is relational, holistic, and cyclic, where everything is alive, has energy, is sacred, is spiritual, and is interconnected. I was taught

this perspective of worldviews twenty-five years ago while working as a helper to a Dakota spiritual healer. These characteristics of Indigenous worldviews are seen in the phrase "all my relations," which I have experienced hearing in Cree and Dakota ceremonies. My learned understanding of the Indigenous worldview is that everything is energy with a spirit and revolves around the moon's cycle. Certain ceremonies are performed during the full moon: there is the full moon ceremony for women, and the Sun Dance starts three days before the full moon, which is the most powerful spiritual time.

As Indigenous scholars have similar but somewhat variable Indigenous worldviews, I focused on the Swampy Cree worldview.

2.2.4 Indigenous knowledge

To supplement an understanding of the complex nehiyaw tapisinowin (Cree knowledge), I cite Napoleon (2014), who argues that "tapisinosinowin or 'Indigenous knowledge' is a knowledge system in its own right…ways of knowing" (p.29).

It is my understanding that our Cree language is interconnected with Cree ways of seeing, thinking, and doing, which impacts our Cree philosophy, values, and beliefs systems, both in nehiyawak (Plains Cree) or Muskego ininiwak (Swampy Cree). Working with Dakota Elders, have related the same thoughts about their worldview. I remember the spirituality aspect was of the utmost importance in the Dakota worldview.

Indigenous knowledge has been here long before the settlers arrived on Turtle Island. (Canada). Our ancestors passed their knowledge to the next generation; our great-great-grandmothers, nohkomak (grandmothers), and nikawiyak (mothers) told us achimowin (stories) when we were young, and now, we pass this knowledge on to our children.

Even though Indigenous knowledge has not been recognized by Western academia in the past, this is changing. Today, Indigenous knowledge is re-emerging by Indigenous scholars with guidance from their Elders. The recognition and incorporation of Indigenous knowledge in academia are very empowering and decolonizing for Indigenous scholars. Battiste (2002) states that "as a concept Indigenous knowledge benchmarks the limitations of Eurocentric theory" (p. 5). Indigenous research is filling the gaps in Western research. Indigenous scholars are developing new analyses, methodologies, Indigenous paradigms, and theories by revisiting the original knowledge keepers, the Elders, as they reclaim their rightful place in sharing their knowledge.

Indigenous knowledge in Muskego ininiwak (Swampy Cree), according to Hart (2002), is like an "effective map, in which ininiw wi-kiskenihtamowin (Indigenous knowledge) then is a part of Indigenous worldviews" (p. 33). Hart (2007) goes on to say that worldviews are "mental lens that are entrenched ways of perceiving the world" (p. 20). There are numerous non-Indigenous scholars' worldviews but limited Indigenous scholars, making it problematic to develop an established description for an Indigenous worldview. Therefore, there is a need for further and deeper discussion between Elders and Indigenous scholars where Elders, the knowledge keepers, share more teachings on the Indigenous worldview. Research is a sacred process that one needs to go through to come to the best understanding of an Indigenous worldview. After all, this concept of Indigenous worldview is the foundation of Indigenous values, beliefs, customs, and traditions.

2.2.5 Principles and Values

This section examines the nehiyaw (Cree) principles and values. Elders prefer to use the word natural laws or guiding principles when people talk about values. Humility and respect,

according to Napoleon (2014), would be the "foundational principles of nehiyaw (Cree) culture, according to the Elders" (p. 82). According to Hart (2002), there are other fundamental principles which are "kindness, honesty or integrity, sharing, strength, courage, wisdom. All these values or principles are important in promoting "mino pimatisiwin" (p. 45).

2.2.6 mino pimatisiwin

mino pimatisiwin, a Cree word, translated to English, according to Hart (2002), means "a good life, or life in the fullest, healthiest sense." (p. 11). The medicine wheel used as a guide, as Hart states, "reflect[s] several key and interrelated concepts…of helping and healing…values and perceptions which are based upon the worldviews of Aboriginal people" (ibid; 39). The medicine wheel is an approach Aboriginal people use in their journey to a good life. Much like in nursing, the nursing care plan provides a guide where a goal is set with planned activities to achieve the expected outcome.

2.2.7 Medicine Wheel

2.2.7.1 Introduction

This section provides a brief history of the medicine wheel, how it has been used by various professions, and a description of the Cree medicine wheel and my personal knowledge shared by Dakota and Cree Elders.

The medicine wheel is an ancient symbol used by various peoples and, according to Hart (2002), "to understand things or ideas which often cannot be seen physically. It reflects the cosmos order and the unity of all things in the universe" (p.39). There are various concepts of the medicine wheel by Aboriginal and non-Aboriginal scholars. Various tribes such as Dakota, Cree, and Anishinaabe use the medicine wheel to share teachings, and perform sun dances. It has been

used as a tool for teaching and healing by various professions, such as clinical psychologists, and medical doctors.

A few scholars have described the Cree medicine wheel theory in their work, such as Hart (2002); Wenger-Nabigon (2010). The medicine wheel is an abstraction of a circle divided into four quadrants. According to Wenger-Nabigon (2010), the "outer circle of the Cree medicine wheel presents the Circle of Life, creation, animals, humans, spirit, and earth. It also represents the past, the present, and the future, negative side [with the center being] core of a person. The author continues by saying, the "inner circle of the medicine wheel represents the positive side or healing. The central circle, where the two lines cross all four quadrants, symbolizes balance and harmony" (p. 143). Indigenous people who walk the red road seek balance and harmony in all aspects of their life.

Hart (2007) argues that the foundational concepts of the medicine wheel are wholeness, balance, and harmony" (p.40-43). Wholeness, according to Hart, is related to "interconnectedness" (ibid; 40) of all living things. As in the four directions of the medicine wheel, there are four cardinal directions in the world; this interconnectedness of these four directions creates the wholeness. At the individual level, each person travels through four phases of their life: child, adolescent, adult, and elder. These phases include "the four aspects of humanness- the emotional, physical, mental and spiritual" (ibid: 40). The holistic, energetic movement through the different aspects of the life cycle creates wholeness.

To achieve wholeness, an individual needs "giving of attention and energy requires balance" [to develop each aspect of life] (ibid;41). According to Hart, balance "occurs when a person is at peace and harmony within their physical, emotional, mental and spiritual humanness; with others in their family, community and the nation and all other living things" (ibid; 41).

The third foundational concept of the medicine wheel is harmony. Harmony, according to Hart, "focuses on established peace with oneself and the world around" (ibid;43). It is a process that involves every living thing " fulfills their obligations and is connected to the growth of a person's body, heart, mind, and spirit (ibid; 43).

Using the foundational concepts of the medicine wheel as a guide and following the principles or values in developing one's responsibility, one can achieve holistic healing. This results in mino pimatisiwin or a good life or good health.

Wholeness conceptualized is the total sum of all its parts. To understand the Indigenous worldview, one needs to understand the different parts such as principles and values and how they are related to each other that make the worldview what it is, as this relates to the concept of balance. To maintain wholeness, balance must be constantly maintained by respecting the relationships between the different parts of the total.

The Cree language is spiritual, holistic, and fluid. According to Michill (2013), to understand the principles and values of the Cree worldview, he states “our way of life is inseparable from our spiritual ceremonies, stories, songs, dances…all of which taken together, reinforce our Cree worldview. Embedded within these cultural expressions are complex teachings, Cree laws, [values] and ethical principles of living” (p. 32).

2.2.7.2 Conclusion

The Cree medicine wheel is a teaching instrument/tool for all humankind to understand the essence of a good life. However, some Indigenous scholars are hesitant to dig too deep into the roots of ancestral knowledge for fear of misrepresenting traditional knowledge.

To have balance and harmony in all relationships worldwide, we as Indigenous people need to share the natural laws our ancestors taught us. The medicine wheel has the wisdom of the

ancestors, the culture and ka is kiskenitaman (ways of knowing), and ka is totaman (ways of doing), and ka is itastasiwin (ways of being). All the ways of knowing, doing, and being result in mino pimatisiwin or a good life.

2.3 Factors Contributing to Increase in HIV Cases in Urban Aboriginal Women

2.3.1. Introduction

The following section examines factors contributing to an increase of HIV-positive cases in urban Aboriginal women. Before we can discuss the factors that may contribute to the increase of HIV infection in Aboriginal women, we need to understand the trajectory of HIV, incidence, and prevalence of HIV infection.

According to Duncan (2011), the incidence rate of HIV infection in the Aboriginal population before 1993 was "1.2% of all new HIV cases, in 2006, newly diagnosed HIV cases in Aboriginal populations was 27.3%" (p. 215). Duncan states there is a "high prevalence rate of HIV among Aboriginal street youth and female sex workers due to illicit drug use and unsafe sexual practices" (ibid; 224).

These statistics show that there has been an alarming increase of new cases of HIV infection since 1998. A key finding is that current HIV prevention strategies are not effective for the female Aboriginal population and that further research is needed on culturally appropriate HIV prevention strategies.

After looking at the incidence and prevalence of HIV in Aboriginal people, I explored the factors contributing to an increase in HIV in the Aboriginal population, focusing on urban Aboriginal women.

2.3.2 Social Determinants of Health

2.3.2.1 Introduction

The following section examines the concept, social determinants of health, and how urban Aboriginal women have been affected. Social determinants of health are factors such as life experiences, workplace, social and economic conditions that shape the lives of urban Aboriginal women.

Czyzewski (2007) notes that the "International Symposium on the Social Determinants of Indigenous Health, had expressed that determinants of Indigenous health were different than the rest of the world population" (p. 1). Nettleton (2008) also argues [Indigenous people see health differently, as a] “state of balance and harmony involving body, mind, emotions and spirit and it links each person to family and community” (p. 7).

The National Collaborating Center for Aboriginal Health (NCCAH) defines distal determinants of health as Czyzewski (2007) “the political, economic and social context within which all other determinants-proximal and intermediate are constructed (p. 3). The guiding force that shapes the conditions between the Indigenous and non-Indigenous relationship is colonialism, which shapes the health of Aboriginal people. The distal determinants are usually beyond an individual's or community's control and are usually the cause for unjust situations in which certain people live.

According to Reading (2015), "distal or root (or structural) determinants of Aboriginal health" [are the] “historical, political, ideological and social foundations which includes Indigenous worldviews, spirituality, and self-determination" (p. 5). Reading uses an Indigenous paradigm describing the distal, proximal, and intermediate determinants of health as three parts of a living tree, all dependent on each other. The distal determinants of health are the tree's roots, the intermediate determinants are the tree's trunk, and the proximal determinants are the tree's crown or leaves**.**

Given the experiences of intergenerational trauma and colonization, Shahram (2016) notes that substance use among Aboriginal women is "rooted in the social determinants of health" (p. 158). The social determinants of health examined here: age, sex, gender, employment, housing, experiences of abuse and trauma, colonialism, culture, and beliefs. Shahram used various sample groups, such as “pregnant Aboriginal teens, pregnant or parenting Aboriginal women, Aboriginal women currently in alcohol and /or drug treatment and Aboriginal women in recovery” (p. 164).

2.3.2.2 Shahram Study on Social Determinants of Health

For the remainder of this section, I examined the social determinants of health that Shahram explored in his study. With socio-demographics as a research characteristic, there appear to be substance use issues later in life with a relationship between age and the start of using substances. The women who started substance use earlier were more likely to have substance use issues later in life. Other findings, Shahram (2016) states, "included living in more than four homes as a child was associated with lifetime methamphetamine use among pregnant women, single motherhood” (p. 165). These would be children taken from biological parents and placed in foster homes. Children are often placed in several different foster homes during their experience with Child and Family Services.

Substance use was a common response to coping with women's painful memories of being physically and sexually abused. According to Shahram (2016), the findings are "consistent in explaining the high rates of violence for Aboriginal women. Results show that “70% of the Aboriginal women had multiple abuses" (p. 166). When including gender as a research

characteristic, we learn that women were less likely to be employed, more likely to live in unstable housing or to be homeless, and are more likely to attempt suicide than men, according to Shahram's study. There is a deficiency in the literature that needs to explore Aboriginal women's understanding of the concept of gender, substance use, and how gender affects other aspects of their lives.

It appears that some teen mothers who had families with conflict had lifetime methamphetamine use. A key aspect in supporting Aboriginal women using substances is to have someone offer positive support rather than talking down to them, which increases the likelihood of substance use.

There is a deficiency in the literature regarding colonialism and substance use in Aboriginal women when including colonialism as a research characteristic. Shahram (2016) states, “40% of Aboriginal women who had a parent(s) attend IRS and two-thirds of the young urban Aboriginal women who use substance were taken from their biological parents” (p. 168).

Employment for women in Shahram's study was sex work. Women who are involved in sex work were more likely to inject cocaine daily. There was no explanation by Shahram for substance use in this section. However, I reason that substance abuse in women in the sex work field may be a defence mechanism to cope with the physical and emotional stress of working on the streets.

According to Pearce (2008), "sexual abuse survivors were twice as likely to be HIV positive," and “mental and health issues and continued exposure to sexual risk are the mediators that increased their rate of HIV infection” (p. 2192).

2.4 Social Determinants of HIV/AIDS

This section examines the social determinants as they relate to HIV/AIDS. The social determinants are socioeconomic status (SES), the impact of early childhood experiences, social support, social cohesion, discrimination, ethnicity, and gender.

2.4.1 Socioeconomic status (SES)

In the findings of a decade-long Vancouver study of people living with HIV, Migone (2007) states, "SES prior to infection to be associated with both disease progression and the chance survival even after adjusting the CD4 count, age at infection, year of infection and use of HIV therapies" (p. 4). Another study found an association between "the nutritional deficiencies resulting from poverty with disease progression and survival among HIV infected women" (ibid;4). According to Migone, other studies suggest "an important association between poverty, behaviours that place people at risk of HIV infection" (ibid;4). Women living in poverty have "limited choices and compromise their ability to avoid high risk situations, and according to Migone this relationship between poverty and HIV/AIDS” (ibid;.5), poverty adds to the vulnerability to HIV and worsens the impact of HIV among Aboriginal women.

2.4.2 Impact of Early Childhood Experience

Migone (2007) states, "evidence linking children who are in emotional turmoil, neglected, rejected and poorly supervised are more likely to be manipulated and abused" (p.5). Several studies associate a "history of physical and/or sexual abuse with engaging in a variety of

HIV risk behaviour and to a continuation or increase in the total number of these behaviours between adolescence and young adulthood (ibid;5). One study revealed that among 327 homosexual men, "35.5% of these men reported being sexually abused as children" (ibid; p.5).

2.4.3 Ethnicity and Gender

According to Migone (2007), ethnicity and gender are "risk markers that correlate with other core fundamental determinants of health status such as poverty" (p. 6). Migone goes on to say Aboriginal women receive education at a lower level, poor housing and living conditions and a "lack of economic resources can force women into survival work where condom use is difficult to negotiate as a consequence of the predominant power relation between men and women" (p. 6). This further increases the vulnerability of Aboriginal women in the risk of HIV transmission. The above social determinants of HIV/AIDS show the "reverence of the broader factors that play in the transmission of HIV/AIDS (ibid;6).

2.4.4 Social support, Social cohesion, and discrimination

Migone (2007) writes that social support, social cohesion, and discrimination play a “role as risk and protective factors for the transmission and progression of HIV/AIDS (p. 5). The well-being of people who have HIV “depend upon the presence of a network of formal and informal support and services". HIV is also transmitted by "discriminatory behaviour of people and governments" (ibid;5). According to Migone, the literature suggests an "important association between social support, social inclusion and social cohesion on one hand and positive health outcomes on the other" (ibid; 5). Social supports "enable people to negotiate life's crises, social cohesion helps to stabilize health-threatening situations by including and accepting people, and by enabling them to participate fully with our families, our communities". On the other hand,

discrimination and stigma play a central role in the defining history of HIV/AIDS and according to the literature, "where discrimination exists the virus is more likely to proliferate" (ibid; 5&6).

2.5 Conclusion

Shahram (2016) argues that "a need still exists to identify and quantify the associations between social determinants and substance use" (p. 170). There is limited literature in this area of socioeconomic factors and substance use among urban Aboriginal women. However, Shahram's study can contribute to my project by providing information on social determinants of health for urban Aboriginal women living with HIV. My research project on the perspectives of the urban Aboriginal women living with HIV regarding social-economic factors and driving forces behind the health disparities of Aboriginal women. These studies have been beneficial to my project regarding the topic of social determinants of health. My research **project contributes** to the existing literature regarding the implications of HIV among urban Aboriginal women.

2.4 Implications of HIV among Urban Aboriginal Women

2.4.1 Introduction

In this section, I examined the social implications of HIV among urban Aboriginal women. There are many physical implications of HIV, too enormous to discuss within the scope of this literature review.

According to Kubik (2009), "sociologists refer to Aboriginal women as being doubly marginalized" (p. 24). Aboriginal women with HIV live with similar health inequalities as the general Aboriginal population. However, Aboriginal women with HIV experience health inequalities in three ways: female, Aboriginal, and HIV positive.

2.4.2 HIV Stigma

According to Logie (2011), “stigma of HIV and discrimination being the principal factors that contribute to the increase of HIV” because the stigma of HIV results in susceptibility “and affects access to HIV prevention, testing, testing care and support” (p. 2).

Other implications of HIV, according to Logie, are “sexism and gender discrimination” (ibid; 2) which can result in mental health issues such as depression and physical health. These factors of racism and sexism can mirror some of the effects of colonization.

2.4.3 Racism

Racism, according to (Bourassa, McKay-McNabb, and Hamptom (2004), is "a biopsychosocial stressor that has severe negative health effects on radicalized individuals" and "sexism is blatantly dangerous to women's health many ways" (p. 23). The authors continue to say that "racism, sexism, and colonialism are dynamic processes rather than static determinants of health" (ibid; 24). It would be safe to say there is a link between racism, sexism, and colonialism in creating adverse health outcomes for the urban Aboriginal women living with HIV. A deficiency in the literature exists, according to Logie (2011), in what is missing is the “association between HIV related stigma and other forms of stigma**” (**p. 2). I also have experienced this throughout my literature review.

The legacy of Indian residential schools and intergenerational trauma goes across generations and impacts young Aboriginal women. As stated by Bingham (2014), "studies done in 1990's with Aboriginal women found that HIV risk behaviors became survival behaviors for these women. The women reported running away at a young age, using substances, exchanging sex for money during their adolescence" (p. 447). In 1991, Bingham citing (Pearce et al. 2000), states the "IRS removed 100,000 children from their homes between 1874 to 1986 and that 13%

of Canada's Aboriginal present population are IRS survivors" (ibid: 442). Many of these survivors experienced physical, emotional, and sexual abuse as children and adopted destructive behaviour patterns.

2.4.4 Cultural Identity

A lack of cultural identity appears to have implications for Aboriginal women. According to Bourassa et al. (2004), cultural identity creates "feelings of self-worth and belonging and this impacts their health" (p.24). A study done in Manitoba by Prairie Women's Health Centre of Excellence revealed that women "endorsed important links between health and wellness and their cultural identities" (ibid;24). The authors state that Aboriginal women can look to "cultural identity as a foundation … to build healthy lives" (ibid;25) …however, "there is a number of women who are unable to draw sense from their cultural identity" (ibid; 25). Cultural identity is essential to Aboriginal peoples; however, through colonization and the residential school era, this was destroyed by assimilation.

2.4.5 Violence Against Aboriginal women

Violence against Aboriginal women, according to Kubik (2009), is "underreported because of the stigma attached to the victim" (p. 25). The silencing is partly due to the continued dominance of negative stereotypes of Aboriginal women, which Kubik states "were historically perpetrated by European colonizers" (LaRocque 2005; Maltzand and Arhambault 1995) (ibid. 26). Some studies state gender-based violence, Kubik (2009) is "a learned behaviour" [associated with] male power, privilege and dominance" (ibid; 26). Violence against Aboriginal women further marginalized women, which usually results in living in poverty and using survival sex to survive, which results in increased risks of HIV transmission.

2.4.6 HIV Vulnerability

With the evidence of increased vulnerability to HIV among Aboriginal women, Bingham (2014) states there are "few prevention strategies that are gender-sensitive and focused on Aboriginal women, [and that] Aboriginal women are 3.5 times higher than non-Aboriginal to be in situations of violence, especially women involved in sex work" (p. 442). This circumstance makes these urban Aboriginal women more susceptible and more vulnerable to HIV transmission.

2.4.7 Conclusion

There are many deficiencies in the existing literature regarding Aboriginal women engaged in sex work. Other deficiencies: the relationships between social determinants of health and substance use in Aboriginal women and a deficiency to better understand the HIV-related stigma to help decrease the stigma of HIV with Aboriginal women experiences.

The existing literature reveals negative consequences for Aboriginal women involved in sex work and substance abuse. There needs to be a platform where Aboriginal women can voice their perspectives on the physical, emotional, mental, and spiritual effects of social determinants of health and HIV.

There needs to be an honouring and acknowledgment of the Aboriginal women who use substances, as I see them as knowledge-keepers. My research study seeks to contribute to the existing literature as I focus on social determinants for urban Aboriginal women living with HIV in Winnipeg, Manitoba. Further research is needed in all aspects of Aboriginal women's lives to empower them and promote mino pimatisiwin (a good life).

Shahram (2016) argues that "a need still exists to identify and quantify the associations between social determinants and substance use" (p. 170). There is limited literature in this area

of socioeconomic factors and substance use among urban Aboriginal women. However, Shahram's study can contribute to my project by providing some information on social determinants of health for urban Aboriginal women living with HIV. My research project on the perspectives of the urban Aboriginal women living with HIV regarding social-economic factors and substance use seeks to contribute to the existing literature.

2.5 Historical Trauma

2.5.1 Introduction

The following section examines the concept of historical trauma as experienced by Aboriginal women. I describe and discuss the characteristics of historical trauma and the effects of historical trauma on Aboriginal peoples.

I argue that historical trauma has left devastating experiences among urban Aboriginal women. Historical trauma has resulted in the breakdown of the traditional roles of iskwewak (women). In pre-colonial society, Aboriginal women were the center of the communities, where they assisted with decision-making for the communities, were the midwives, healers, and caregivers to all families. As these women were the backbone of the community, when degradation of their leadership positions occurred, the community fell apart.

2.5.2 Historical trauma

The concept of historical trauma is the physical, emotional, psychological, and spiritual losses and traumatic experiences that the Aboriginal women suffered and still suffer due to colonization. According to Kirmayer, Gone, and Moses (2014), "historical trauma, loss and grief have drawn attention to the enduring effects of colonization, marginalization and cultural oppression" (p. 313) in the lives of the urban Aboriginal women.

Before contact with European settlers, Indigenous peoples in North America were independent and had traditional governance, Indigenous philosophies, and approaches to economics and cultural and educational matters. Five hundred years of colonization and assimilation have devastated Indigenous communities. They have experienced multiple losses: loss of land, language and community, traditional culture and knowledge, and traditional governance. All these losses have resulted in traumatic experiences, such as loss of parenting skills among the residential school survivors who learned negative behaviors such as physical, emotional, and sexual abuse, passed on through the generations. The effects of traumatic experiences resulted in Bombay (2014) in "behavioral, psychological events such as depression, self-destructive behavior, suicidal thoughts, anxiety, low self-esteem, anger and substance abuse" (p. 324).

2.5.3 Characteristics of Historical Trauma

- Evans-Campbell (2008) classifies these characteristics of historical trauma events: the event was widespread among a specific group of the population, with many group members being affected
- the event was perpetrated by out-group members with a purpose
- the event generated high levels of collective distress in the victimized group. (p. 321). Today, these traumatic events continue to affect Aboriginal peoples' well-being, and these responses are intergenerational. (Bombay 2014, p. 322).

Since the last Indian residential school closed in 1996, there are still IRS survivors, as evidenced by the Truth and Reconciliation Commission hearings. According to Duncan (2011),

there is a “large portion of the Aboriginal population in Canada that meet the criteria of historical trauma events” (p. 322) which sanctions the concept of historical trauma.

2.5.4 Conclusion

Historical trauma is related to my research project of urban Aboriginal women, as a large portion of the Aboriginal women I worked with had firsthand or second-generation experience with Indian residential schools.

According to Bombay (2014), "more research is needed to further explore this phenomenon (intergenerational effects of IRS) of individuals from families in which multiple generations attended IRS" (p. 332). There is a deficiency where much Indigenous research guided by the Indigenous Elders is needed in how the role of trauma plays in the lived experience of Indigenous people. Included in the deficiencies is the lack of interventions recommended to address the intergenerational trauma of future generations.

I explored further aspects of how and if intergenerational trauma may have affected the urban Aboriginal women in my study. My research project seeks to contribute to the existing literature on historical trauma and its effects on urban Aboriginal women in Winnipeg, Manitoba.

2.6. Colonialism

2.6.1 Introduction

This section is a review of the concept of colonialism and its effects on urban Aboriginal women. After stating that historical trauma has affected the Aboriginal iskwewak (women), I build my argument that colonialism has also destroyed the Aboriginal traditional role of iskwewak (women), resulting in cultural oppression.

I discuss the traditional role and responsibilities of traditional iskwew (women) before colonization. I provide a brief history of the ininiwak iskwew (Swampy Cree women of Fisher River Cree Nation kayas (before 1950) and today, as an illustration of how the traditional roles of iskwew (women) are slowly being reclaimed.

2.6.2 Colonialism

Colonialism, according to Czyzewski (2011), is defined as 1) "the control or governing influence of a nation over a dependent country, territory, or people; 2) the system or policy by which a nation maintains or advocates such control or influence". Random House, 2010. (p. 1). Colonialism remains in Canada today in the policies and programs of the federal government of Canada. Aboriginal people across Canada are still trying to recover from the effects of colonialism. Despite the horrific events that had happened to the Aboriginal people, their resiliency has made it possible to survive.

2.6.2.1 History of colonialism

Kubik (2009) argues that colonialism is one of the most destructive elements "affecting child-rearing practices, societal and spiritual life work and social activities" (p. 19). With the beginning of settlers in Canada, Kubik continues to say Indigenous people "were valued as a source of wealth" (ibid;19) through the fur trading era. However, when the economy changed to industrial, things began to change for the Aboriginal people. The industrial economy was focused on the use of natural resources and control of lands. Aboriginal people were no longer valuable but seen as a problem, as the land they were living on was needed by the settlers.

In 1876, subjugation and domination were carried out by the patriarchal values and practices when the Canadian government passed the Indian Act**.** Kubik (2009) states,

"assimilation policy through the process of disenfranchisement or losing one's Indian status" (ibid; 21) occurred. One example of this disenfranchisement occurred when Aboriginal women married non-Aboriginal men - the women were disenfranchised and could not live in the community. Many women and their children moved into urban areas. (Bourassa, McKay-McNabb, Hampton; p.25).

According to Bourbassa (2004), the Indian Act defines “Indian identity and Indianness” (p. 25). Because of the sexist conation associated with Indianness, the ramifications of the Indian Act are “more severe for Aboriginal women than men” (p. 25). Kubik (2009) states, "today Aboriginal women face the highest of poverty and violence rates in Canada" (p. 25). The Aboriginal women mortality rate in Canada is three times the rate of non-Aboriginal women. According to Stats Canada (2016), Aboriginal women in Canada have higher rates of poverty, ill-health, sexual and violence abuse due to the destructive effects of colonization. Bourassa et al. validate what Kubik states when they write, "Aboriginal women have the highest poverty and violence rates in Canada" (p. 23). Borrows (2013) writes that the leadership of Aboriginal communities needs to take responsibility for recognizing the violence against women and lobby the government for changes to Sec 35.1 & 4 of the Constitutional Act. (p. 717).

2.6.3 Roles of traditional ininiwak iskwewak (Cree women) pre-colonial

2.6.3. iskwewak (Women) as protectors of nipi (water)

One of the critical roles of traditional iskwewak (women) is the protector and the voice for nipi (water). Women have a special bond or relationship with nipi (water). Women physically carry life for nine months. The baby is surrounded by nipi (water) or amniotic fluid, a home for

the unborn baby. The nipi (water) protects, cushions, comforts, and gives a sense of security for the baby.

According to McGregor (2012), nipi (water) “is alive with a spirit, sacred and respected by the Aboriginal peoples” (p. 10). Today, some traditional women have taken up their role as water protectors doing water walks to bring awareness to the importance of water and how water is being disrespected. The late Elder Geraldine Mandamin of Ontario started the Women's Water Walk, walking around Lake Superior. She started in 2003 and walked every year until 2017 around Lake Superior to raise awareness of the water crisis in Canadian Aboriginal communities. Her traditional role as water protector resulted in the "Chiefs of Ontario…drafting the "Water Declaration of the Anishinabek, Mushkegowek, and Onkwehonwe" …which recognizes the special role of women with regards to water and the environment" (p. 9). By this Elder doing her part in bringing awareness to communities, she has fulfilled her responsibility in Indigenous governance.

2.6.3.2 Women as healers

According to Struthers (2000), states “in all cultures, women have traditionally been society’s healers…as healing has been regarded as the natural responsibility of mothers and wives" (p. 261). Throughout the history of the Anishinaabe, Cree, and Dakota nations, women have practicing healing, despite harassment by missionaries.

I recall my mother sharing stories with me about two women who were traditional healers in the community of Fisher River Cree Nation. piyak ininiw iskwew (one Cree woman) was a midwife who helped with home births for the women since there was no hospital in the area. Another ininiw iskwew (Cree woman) gave people different herb medicines for various ailments.

It has been my experience that some women in Fisher River in this present time are reclaiming their traditional responsibilities as healers by performing healing sweats, healing fasts, and using herb medicines for people requesting their services.

As Struthers (2000) states, "accepting who you are, your way, your teachings, your culture and your spirituality is paramount as a human being" (p. 276). We all have our gifts; some women become nurses, doctors as in the western way of knowing and return to the traditional roles of our culture. While working as a nurse, I was a helper for a Dakota spiritual healer. My work as a helper is where I learned most of my traditional ka is kiskenitaman (ways of knowing), ka is totaman, (ways of doing) ekwa ka is itastasiwin (and ways of being)

2.6.3.3. Present Day

The effects of colonialism resulted in the breakdown of the traditional roles of Aboriginal women. Colonialism has caused a lack of respect for Aboriginal women as leaders and healers. The patriarchal views of settler men toward all women in general created negative consequences for Aboriginal women when Aboriginal men adopted the colonial attitude.

According to Hall (2011), "Aboriginal women's societal positioning and authority were undermined by missionaries and the government influences severely impacted their economic and social autonomy" (p.69). Aboriginal women were regarded, as Hall writes, as "mothers of our nations as they were the 'life givers' through their ability to bear children and foster healthy communities" (ibid;69). The pre-colonial, equalitarian way of life has been replaced by patriarchal values such as lack of respect for women, physical, emotional abuse by the Aboriginal men and the settlers. Aboriginal women, including women Elders, are disregarded and are not being heard in leadership.

The patriarchal political system still rules, the Indian Act still controls Aboriginal people. Although Aboriginal leaders have attempted to remove the Indian Act, it remains intact with a few amendments.

2.6.3.4 Native Women's Association of Canada

Presently, there has not been much change for the betterment of Aboriginal women; instead, conditions have worsened. Aboriginal women are vulnerable, and many young female youth and women have gone missing or murdered. The Native Women's Association of Canada (NWAC) (2004) has reported "79 cases of missing and murdered Aboriginal women and girls in Manitoba and accounts for 14% of all cases in NWAC's database…81% of cases in Manitoba are murder cases…and 64% of murdered cases have in Manitoba occurred in urban areas" (p.1-2).

The Native Women's Association of Canada (2004), report "three quarters of Aboriginal women have experienced family violence and the mortality rate for Aboriginal women due to violence is three times higher for Aboriginal women than non-Aboriginal women" (p. 4). According to NWAC (2004), with higher rates of violence, Aboriginal women tend to use illicit drugs as a defence mechanism. To support their addiction, the Aboriginal women may turn to sex work, further increasing the risk of contracting HIV infection (p.3-4). All these factors are interconnected, which can create socioeconomic inequalities for Aboriginal women.

According to LaVallee (2010), "colonization has attempted to strip Indigenous people of their cultural identity" (p. 4). The Canadian government banned the practice of Indigenous spiritual ceremonies and the speaking of Indigenous languages. These efforts at colonization have impacted mental health, or as LaVallee (2010) states, "colonization has wounded the spirit of Indigenous peoples" (p. 5).

2.6.3.5 Looking to the future

The United Nations Declaration on the Rights of Indigenous Peoples was signed in Ottawa in 2006, almost ten years after the General Assembly of the United Nations adopted it. By honouring this document, Canada is responsible for fulfilling its responsibility to the Indigenous peoples of Canada in building better relationships with all.

In 2015, Indian residential school survivors relived the horrors they experienced as they shared their stories during the Truth and Reconciliation Commission hearings. On the other hand, this was an exciting time in the history of the Indigenous peoples of Canada. A name put to the root problem - colonialism, which has created health disparities for Aboriginal women. The TRC is only the beginning of a long, hard journey of recovery and healing in the process of reclaiming our languages, cultures, traditions, and healing.

The Native Women's Association of Canada met with Prime Minister Justin Trudeau in 2019 to discuss "the Implementation of the Canada -NWAC Accord and …development of all policies, programs, and legislation to ensure a culturally-relevant gender-based lens" (p.30). Included in the discussion, NWAC advocated implementing the United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP). The advocacy and pressure from the NWAC on the government to implement these documents give hope that the status of urban Aboriginal women will improve.

As Elder Mae Louise Campbell (2019) states, "It is up to the Aboriginal women, grandmothers, mothers to reclaim their traditional roles and teach the traditional parenting to the

young people and to assist our Aboriginal leaders in their political positions" [in reclaiming our traditional governance]. (M. L. C. personal communication. February 21, 2019).

2.6.3.6 Conclusion

I have looked at the history of Aboriginal iskwewak (women) regarding the effects of colonialism. I have also collected stories of present-day Aboriginal women living with HIV and examined this data for any effects of colonialism. Colonialism has affected and continues to affect all Aboriginal people in Canada. Although there is existing literature on colonialism, there has been a resurgence of Indigenous scholars addressing the effects of colonialism by providing Indigenous ways of knowing of traditional healing methods for Aboriginal people to begin the process of recovery and healing.

The existing literature on colonialism will contribute to my project by providing some information on the effects of colonialism on urban Aboriginal women who live with HIV. My research project seeks to contribute to the existing literature in providing updated data regarding colonialism that emerges from the perspectives of the urban Aboriginal women who live with HIV. As the two sub-themes, colonialism and Indian residential schools, are interrelated regarding urban Aboriginal women, I provide the effects of colonialism and IRS in the conclusion of the next section.

2.7 Indian Residential Schools

2.7.1 Introduction

The following section examined the effects of Indian residential schools among Aboriginal women and concluded with the effects of colonialism amongst Aboriginal women**.**

2.7.2 Indian Act

In the 1920s, the Canadian government amended the Indian Act, where it was, according to Kubik (2009), "illegal for Indian children to stay home from school" (p. 22). The Canadian government built many residential schools across Canada, using education to instill Kubik their “racist ideology” (ibid: 20) as one mechanism to assimilate Aboriginal children. These schools opened, Bombay (2014) in “1880's until the last school closed in 1996” (p. 322).

The Canadian government forced Aboriginal parents to send their children as young as five years old to Indian residential schools. The school staff taught generations of children to feel shame about their culture, customs, and language and instilled fear, punishment, and abuse. The forced assimilation of Aboriginal children destroyed the traditional Aboriginal family.

Parents suffering from the separation of their children began to consume alcohol to kill the pain and hurt. According to a friend who went to IRS, whose parents were IRS survivors, going home was not a happy occasion. It felt like home was not her home anymore, her parents felt like strangers, and they consumed alcohol most of the week.

The residential schools created generations of Aboriginal women with poor parenting skills, no Indigenous language, and no self-identity as a people. The young women did not experience loving, nurturing experiences during their childhood and adolescence. Many of them suffered physical, emotional, and sexual abuse from the staff and missionaries of the residential schools. Staff punished them when they spoke their Indigenous language. Loss of cultural practices and loss of self-identity has led to Aboriginal women becoming vulnerable victims of physical, emotional, sexual, and substance abuse.

2.7.3 Child and Family Services

All these losses have created generations of children as residential school survivors. These children become wards of Child and Family Services due to lack of parenting, such as neglect of children and parental substance abuse. According to Families Minister Scott Fielding (2017), approximately eleven hundred children are in the care of Child and Family Services in Manitoba, and ninety percent are Aboriginal children. These children in care frequently become permanent wards of Child and Family Services until they are eighteen years old.

Aged out, these eighteen-year-old youth (no longer the responsibility of Child and Family Services) are given their freedom and expected to fend for themselves with little preparation of life skills. Many end up homeless and become involved in substance abuse and survival sex. Former wards become involved with the police due to stealing, ending up in the Youth Center for Juveniles. According to Statistics Canada (2015-2016), thirty-nine percent of admissions to the Canadian Center of Justice in nine jurisdictions were Aboriginal youth aged 12 to 18 years. Aboriginal youth are at risk of being in situations where illicit intravenous substances are available, further increasing the risk of unprotected sex and possible transmission of HIV.

These teenagers become adults and have babies whom Child and Family Services possibly take for various reasons. Aboriginal children in care can be an endless, vicious cycle of human beings growing up with no parents, no love or nurturing, and possibly no hope for the future.

2.7.4 IRS example of Historical Trauma

According to Evans-Campbell (2004), the Indian residential school era is an example of historical trauma as it has the three characteristics of historical trauma (p. 21). Some children of the residential school era experienced chronic mental, physical, and sexual abuse.

There is growing evidence Bombay (2004) that "the children of residential school survivors are at a greater risk of poor well-being" (p. 323). The literature also suggests that the residential school era continues to impact the health and well-being of present Aboriginal people. Studies state that individuals with a family member who attended IRS "interact more frequently with contemporary stressors and relatively greater effects of stressors on well-being" (ibid: 323). Having attended the IRS can increase the individual's adverse effects on their well-being through the generations.

Most of the research on historical trauma responses to familial IRS attendance focused on psychological effects in children and grandchildren of people who attended IRS. This information is relevant to my research project as, through my past work experience, I know that some of the urban Aboriginal women living with HIV have attended IRS or had a parent who attended IRS.

Bombay (2014) states the First Nations Information Government Committee (FNIGC, 2007 p. 7) reported:

> 26.3% of First Nations youth with a parent who attended IRS had thoughts of suicide, 18.0% of non-IRS youth reported thoughts of suicide. First Nations youth who had a parent attend the IRS were more likely to report having learning difficulties at school, the difference being 48% compared to 40% whose parents did not attend the IRS. Young Aboriginal drug users (N=512, aged 14-20) who had a parent who attended the IRS were more likely to contract Hepatitis C or HIV [p. 32].

As this data collected by FNIGC is considered preliminary research, there is a deficiency in the literature regarding the effects of the IRS on survivors, their children, and grandchildren. More perspectives of Indigenous survivors and the effects of IRS would significantly add to the topic

of IRS and its effects on the Aboriginal women living with HIV. This preliminary data on IRS relates to the urban Aboriginal women living with HIV in Winnipeg, Manitoba. The legacy of the IRS has left its mark on the survivors as Bingham (2014) cites Dion Stout and Kipling (2003) “many died an early death because of suicide, violence or alcohol-related causes” (p. 442). The impact of this legacy of IRS continues to impact Aboriginal women today. Bingham argues women described "histories of turbulent family relationships, parental residential school experiences, parental substance abuse, physical abuse, and sexual abuse" (ibid: 447). Bombay states there is limited “empirical literature regarding describing the phenomena of historical trauma” (ibid; 231). The limited literature may be partially due to researchers' different explanations of historical trauma as a described response and cause of disparities. I explored with urban Aboriginal women living with HIV further aspects of how and if intergenerational trauma and the effects of the IRS may have affected them. I argue the urban Aboriginal women living with HIV who experienced physical, sexual, and emotional abuse while attending IRS may experience low self-esteem, poor self-worth, and depression, leading to an increased usage of illicit drugs. These emotions can result in a risk of sex work to support the drug addiction, increasing the risk of HIV transmission.

The IRS relates to my research project as some urban Aboriginal women living with HIV have been affected by their IRS experiences. Some Aboriginal women shared stories of physical violence and emotional abuse from spouses related to their HIV status. Other Aboriginal women depended on sex work to financially support their drug addictions, increasing the risk of contracting the HIV infection. There is a deficiency in the existing literature of how trauma plays out for Aboriginal women living with HIV. The existing literature would contribute to the body of knowledge regarding historical trauma and urban Aboriginal women living with HIV.

2.7.5 Conclusion

The effects of colonialism and the Indian residential school era among the Aboriginal women has resulted in intergenerational trauma; poverty, physical and psychological issues, such as low self-esteem, poor self-worth, and depression leading to the increased usage of illicit drugs, which may lead to sex work, increasing the risk of HIV transmission. With mainly adverse effects resulting from the IRS era and colonialism among the Aboriginal women, I hope to highlight the positive outcomes that emerge from the stories of the urban Aboriginal women who live with HIV.

According to the literature, intergenerational trauma is a factor contributing to substance usage in urban Aboriginal women who live with HIV.

Chapter nisto (three)

Promoting mino pimatisiwin (A Good Life)

3.1 Introduction

I examine the Cree concept of mino pimatisiwin (a good life), western health, and blended methods and Indigenous healing methods. I argue mino pimatisiwin and returning to traditional healing can improve the lives of urban Aboriginal women and increase their self-determination.

3.2 mino pimatisiwin

Traditional healing, defined by World Health Organization, Hall (2011), is

> Practises designed to promote mental, physical, and spiritual well-being are based on beliefs that go back to before the spread of western scientific biomedicine. When Aboriginal peoples of Canada talk about traditional healing, they include a wide range of activities, from physical cures using herbal medicines and other remedies to promoting psychology and spiritual well-being using ceremony, counselling and the accumulated of elders. (RCAP, 1996, Vol.3, 348) (p.63).

mino pimatisiwin, a Cree phrase, translated to English, according to Hart (2002), means "a good life or life in the fullest, healthiest sense" (p.11). To achieve good health, one needs to heal from an illness or a traumatic event. Healing, according to Struthers (2000), is "the return to natural state of integrity and wholeness of an individual…bringing together aspects of one's body, mind and spirit" (p. 261).

The medicine wheel is used as a guide Hart (2002) to “reflect several key and interrelated concepts…of helping and healing…values and perceptions which are based upon the worldviews

of Aboriginal people" (ibid:39). The medicine wheel is an approach Aboriginal people in their journey to a good life. Much like in nursing, the nursing care plan provides a guide where a goal is set with planned activities to achieve the expected outcome.

Using the foundational concepts of the medicine wheel as a guide in developing one's responsibility and following the principles of natural laws, one can achieve holistic healing. Healing results in mino pimatisiwin or a good life or good health.

The previous section examined the concept of mino pimatisiwin (a good life). The theoretical frameworks of Western knowledge and Indigenous knowledge of health have differences. Aboriginal peoples view health as holistic and relational. They include the spiritual aspect of life as part of health and a relationship with Mother Earth. Western understandings of health may not include the spiritual aspect in the concept of health.

3.2.1 Health as a contemporary Indigenous concept

According to Graham (2010), there is a deficiency in the literature describing Indigenous health perspectives. Graham (2010) notes that "Aboriginal people understand and define health, address their health concerns and perceive barriers to obtaining optimal health" (p. 6).

Graham (2010) combined the perspectives of Plains Cree participants into the following definition of Indigenous health "a state of physical, mental, (intellectual), emotional, and spiritual wellness, and includes economic, political independence" (p. 14). As previously stated, there was criticism about the World Health Organization's definition of health. With Graham including the word "state" (ibid: 6) in her definition, it remains to be seen if criticism of this definition will occur in future literature.

3.2.2 Health as a Western concept

As previously discussed, and according to World Health Organization (1948), health is "a state of complete physical, mental, social well-being." The spiritual aspect of health is included in mino pimatisiwin; therefore, one can say that a good life includes the physical, mental, social, and spiritual aspects of well-being.

3.2.3 Conclusion

I have examined the concepts of mino pimatisiwin (the good life) and western health**.** I have noted some differences between western and aboriginal concepts of health. In the next section, I discuss blended methods of healing.

3.3 Blended Methods

3.3.1 Introduction

This section examined two blended methods promoting mino pimatisiwin (a good life). According to Menzies (2010), there is a deficiency in the literature on intergenerational trauma from a clinical perspective (p. 70). His research involved finding indicators for intergenerational trauma using an Indigenous worldview and qualitative methodology. Menzies includes Aboriginal stakeholders, Aboriginal participants in the study and developed the Intergenerational Trauma Model.

3.3.2 Intergenerational Trauma Model

By incorporating the traditional teachings of the medicine wheel in counselling sessions with individuals, he explains the Indian Act, IRS, and colonialism and how these occurrences have affected their lives. This model is intended to help “social workers to move away from traditional

assessments and consider that many Aboriginal people have been involved in social systems because of unresolved grief" (Menzies 2010, p. 60).

Menzies argues that this model can be incorporated into the western medical model of care. However, the western medical and nursing professions need to learn and understand the various aspects of the governance system, such as the Indian Act, and the reason behind the Indian residential school for generations of Aboriginal children.

There is some mention of traditional teachings and utilizing Western methods in counselling. Therefore, this can be considered a blended method. As this model is relatively new, there is a deficiency regarding evaluation as to how effective the model is in promoting mino pimatisiwin in Aboriginal people.

3.3.3 Two-Eyed Seeing Model

Marsh (2015) uses an Indigenous paradigm to explore blending Aboriginal and Western healing methods to treat substance use in Aboriginal people. He argues, "Western treatments have failed to address the needs of Aboriginal people because they do not understand traditional spiritual and healing methods" (p. 2). Many compounds in pharmaceutical medications are derived from wild plants or weeds, which Indigenous people call "medicine." I received the following knowledge from my late mother-in-law, whom I consider an Elder in her own right. Medications such as "digoxin, a cardiac medication is derived from the foxglove digitalis plant" (Crampton 2017 p. 1) and aspirin is derived from "willow bark or spirea shrubs" (Arborg 2009 p. 79).

Two-Eyed Seeing, a blended method of Aboriginal and Western methods, was developed under the guidance of spiritual leader Chief C. Labrador from Nova Scotia. Marsh (2015) states

one "learns to see with one eye, the strengths of Indigenous knowledge and ways of knowing and with the other eye sees the strengths of Western knowledge and ways of knowing" (p 2). According to Marsh, this program has been successful with “African Americans, Hispanics, and Asian Americans internationally (ibid: 2).

Blending the niso ka isi kiskenitaman (two ways of knowing) can be a challenge. The Western approach to knowledge is individual ownership, and the Aboriginal approach to knowledge is relational and community-owned. Blending the two could lead to further oppression of Aboriginal people. To prevent this from happening, Marsh (2015) argues that “blended approaches need to respect and acknowledge each individual and their own belief system” (p. 6). The Two-Eyed Seeing counselling program is a holistic and integrative approach. Its main objective is to help participants build on their coping skills and learn values such as respect and healing of self. It is intertwined with traditional protocols, such as smudging, sharing circles, and sweats. Using a blended healing method is new in Canada, so further evaluation of the program's effectiveness will be required; this would be considered a deficiency in the literature.

3.3.4 Conclusion

. It is very hopeful to learn that some people embrace the principles of Indigenous knowledge, blending with Western knowledge to serve the people in need. There are various other blended methods in the literature. However, these two blended models appeared to have an equal balance in the relationships between the Indigenous and Western methods.

The two blended methods of promoting mino pimatisiwin appear to be relatively new methods of healing. Therefore, further research is needed to evaluate the effectiveness of these two healing methods, creating a deficiency in the literature.

3.4 Indigenous Methods

3.4.1 Introduction

The following section examines Indigenous methods of healing in promoting mino pimatisiwin (a good life).

A new significant area of literature is emerging which looks at the flexibility of Aboriginal people. Despite the negative impact of intergenerational trauma, the Aboriginal people have managed to survive and are working towards healing from their trauma. Goforth (2007) argues that researchers have taken the "concept of resilience one step further by researching protective strategies that foster cultural resilience" (p. 187).

These protective strategies can be described as the traditional and cultural ways of the Aboriginal people that have been oppressed by colonization. Although this may seem a new contribution to research, many Aboriginal people's traditional and cultural ways have always continued. Aboriginal peoples practiced some ceremonies underground to survive and to avoid punishment by the Canadian Federal Government and church authorities. Although not all Aboriginal people practice their traditional ways, the individual would decide this option, as some Aboriginal people have traded their traditional beliefs for Christianity. The resilience of the Aboriginal people has always been present. However, there has been a resurgence and reclamation of the traditional ceremonies in public view in the past fifty years.

According to Goforth (2007), there is a deficiency in the literature for Aboriginal healing methods, as he needed to expand his area of "research to sociology, psychology and education"

(p.12**).** I have also experienced this to be true while doing my research on this topic of Indigenous methods of healing. What I have written about the ceremonies here has come from my way of knowing, and by listening and talking with various Elders.

3.4.2 Aboriginality Spirituality

According to Hatalo (2008), the ability to understand "Aboriginal worldview and perspectives on [Aboriginal] spirituality is important to better understand …[Aboriginal] notions of health and healing" (p. 7). Just as there are various religions in Western ka isi kiskenitaman (ways of knowing), so are various ka isi kiskenitaman (ways of knowing) of Aboriginal spirituality.

However, one common belief in Aboriginal spirituality is Creator or Great Spirit. Creator is known as an entity who is responsible for all creation, human life, and all existence. Hatalo (2008) states, "Aboriginal concept of Creator [can be seen] as an eternal spiritual force characterized by a strong internal and external presence of nurturing care and unity" (p. 7). Aboriginal people believe that all creation is interconnected through Creator; therefore, everything is considered sacred.

Aboriginal peoples have several ceremonies, according to Hatalo (2008), that are known as "psychological medicine" (p. 7), the area of the emotional aspect of health and well-being. Aboriginal peoples are familiar with the role of ceremony in healing, especially spiritual healers in the past and present time. The sweat lodge and Sundance are two sacred ceremonies that experience connections with the spiritual realm. Spiritual healing can result through these ceremonies in that an individual can be motivated into changing their perspectives on their moods and illness.

Aboriginal peoples believe that illness results from an imbalance of one of the four aspects of the physical, emotional, mental, or spiritual. Therefore, traditional healing would be a process that re-aligns an individual's imbalance with the rest of the human aspects to create balance and harmony.

As mentioned previously, healing is part of spirituality. Spirituality is considered a part of mino pimatisiwin, a good way of life. Spirituality is individual, positive values and behaviours in which people learn to understand and begin the process of change. Goforth (2007) states that, according to Elders, “recovery is not a dramatic instant [change] but a slow process. Healing is a lifelong process of learning and transformation” (p. 22). Healing is the process of "decolonization, reclamation of culture and social practices and to claim Aboriginal identity" (ibid: 22). To heal from the effects of a loss of culture and social practices, Aboriginal people who have lost their cultural identity need to re-learn, re-discover, and re-claim who they are. This transformation will need tools to facilitate this process. One such ancient learning and teaching tool is the medicine wheel.

The medicine wheel is a "tool for each individual to work with on gaining knowledge and self-development and to return to one's wholeness, connectedness, and balance in the world" (ibid: 22).

3.4.3. Aboriginal Healing Methods

1. Smudging - an ancient art practiced by Indigenous peoples in North America is a ceremonial daily act of cleansing and purification which uses sage or sweet grass. The smoke is believed to cleanse any negative energy and purify living spaces, people, and objects such as computers and papers when researching.

2. Sweat Lodge - a sweat lodge is usually a dome-shaped frame of willow branches covered with canvas. Heated rocks (called grandfathers and grandmothers) are placed in the lodge's fire pit located in the center. According to Rice (2005), "water, fire, earth and air plus the people conducting the Sweat Lodge ceremony are linked in a purification rite" (p.26). The water is life-giving, the fire in the center is powerful, the rocks represent the earth, while the steam from the rocks represents the breath of life. The people acknowledge the four elements. The environment is one of sacredness and humility. The Sweat Lodge's purpose is to clean one's body, mind, spirit, and healing. There is an expression that you are entering the womb of a mother when entering the sweat lodge - like being reborn.

3. **Sun Dance** - the Sun Dance is a highly sacred and powerful healing ceremony and another method of Aboriginal sacrifice for healing and giving thanks to Creator. All these sacred ceremonies are led by an Elder who is well respected in the community (L. M. personal communication. January 21, 2015).

4. Traditional drumming and singing - These activities are considered medicine by the Elders, therefore, sacred. Drumming and singing have been used for healing and self-expression for centuries by Aboriginal peoples. The beat of the drum is considered the heartbeat of Mother Earth; the sound of the drum grounds and centers you. It promotes self-confidence when one sits at a drum to play or sing traditional songs.

5. Sacred teaching of the Cree medicine wheel - The Cree medicine wheel is a paradigm used by Wenger-Nabigon (2010) to examine "various theories such as Uranjnik, Levin & Gang (2008) the five major areas of child development, **maturation, and learning**, motor development, cognitive, language, and emotional and social development" (p.151). According to Wenger-Nabigon, the Cree medicine wheel with the four doorways, the life cycle, sacred teaching in each

doorway, both positive and negative, provides us with the "theories of the different stages of human development…role of relationship with humans and all Creation, spirituality ... and the interconnectedness of "nested environments" (ibid: 158).

The Cree Elders teach the seven sacred teachings of the Cree medicine wheel during each stage of the life cycle. All seven teachings are taught and re-taught to the individual through muskego ininimowin (Swampy Cree) storytelling, usually by land-based activities such as hunting food for the males; beadwork activities for the females.

- **piyek (1)** Respect is the ability to honour or show consideration for something or someone (Elders as teachers) given to you by Creator. When a male goes hunting and kills a deer, he places tobacco on the ground as an offering to Creator and spirits for the ability to receive food. This act is an example of respect. The interconnectedness of all creation is revealed in this ceremony.
- **neso (2) Honesty**: the Cree sacred teaching of honesty is the action of an individual telling the truth about what they saw, heard, or did. It is important to follow and keep the natural laws of Creator.
- **nisto (3) Wisdom:** the Cree sacred teaching of wisdom is when people use the gifts from Creator. These gifts are to be used for the betterment of other people.
- **neyo (4) Humility:** the Cree sacred teaching of humility acknowledges a higher power (Creator) than oneself. Humility is the action of accepting that all creation and humans are equal.
- **niyanan (5) Truth:** the Cree sacred teaching of truth is to understand all the natural laws made by Creator and be faithful to these sacred teachings.

- **nikotwasik (6) Love:** the Cree sacred teaching of love is knowing the Creator. Great Spirit gives us love to care for ourselves and others.
- **tepakohp (7) Courage:** the Cree sacred teaching of courage is the mental and moral courage required to face fears or challenges that are barriers to achieving a true spirit or self (Wenger-Nabigon 2010).

The seven sacred teachings or natural laws of creation form a paradigm or model that an individual is responsible for learning. Following these sacred teachings creates a good life, or mino pimatisiwin, which the ininimiwak (Cree people) strive to achieve.

This Cree medicine wheel paradigm can be used by everyone worldwide; they are transferable to any culture or society. As Wenger-Nabigon (2010) states, the medicine wheel provides a "theory about human development" (p.158).

Reclaiming Traditional Ways

According to Marsh (2015), the key to healing from intergenerational trauma is "reclaiming traditional values, beliefs, philosophy, approaches and adapting them to the needs of today" (p.4). Although there is existing literature, Aboriginal scholars need to engage with Elders about Aboriginal healing methods from intergenerational trauma.

6. achimowin (Storytelling)

achimowin (storytelling) is an ancient "traditional Cree method used as a foundation for holistic learning, relationship building, and experiential learning [continues to say], the act of storytelling fosters reciprocal engagement, requiring active listening and sharing" (Michill 2015 p. 5). achinmowin (storytelling) is a way of having people partake in "critical thinking, relating" with other people (p.9). Participants can use different media during the storytelling, such as a

drum, songs, a talking stick and other aids in reinforcing the mental, spiritual, physical, and emotional aspects depending on the purpose of the storytelling circle.

Wilson (2008) states that, according to Elder Jerry Saddleback, "there are three levels of [achimowin] storytelling…highest level are the sacred stories…second level stories legends…certain morals take place…third style of story is" the storyteller's personal experience or other people's (p. 98.). Elders using their own stories can help by giving teachings to the people.

6. 1 Functions of Storytelling

I blend the western ka isi kiskenitaman (ways of knowing) and Aboriginal ka isi kiskenitaman (ways of knowing) in discussing oral storytelling. Stories are powerful tools that connect people, heal barriers, and heal wounds. When a storyteller weaves his/her plot and plan together, it encourages us to become invested in the success or failure of the plan.

According to Zak's research on the neuroscience of storytelling, hearing a story encourages the release of the hormones, oxytocin and cortisol which control such things as empathy and social interactions" (2015 p.1). When a story introduces a person with a problematic issue, oxytocin causes the brain to empathize with the person's situation; and cortisol causes the brain to feel stress over the person's issue. These two hormones' interactions lead the researcher/listener to invest in the person's predicament. This connection can be strong, where it moves people to action.

The power of a story engages the brain to have an impact, increasing the brain to engage more, which increases thought and memory. When these two increase, engagement and memory are focussed in a good way. Storytelling can be a key to healing.

6.2 Healing Power of Storytelling

Storytelling is central, the foundation of the cultural and oral traditions of Aboriginal peoples. According to Evans (2008), Renda Dionne, a clinical psychologist and member of the Turtle Mountain Band of Indians, says "stories are how we come to understand ourselves and the world around us (p. 2). Dionne continues to say that for Indigenous people, "stories are medicine…being in the present with yourself and the audience and speaking from the heart" (ibid:2) and can be an effective way of starting the process of healing.

For Indigenous people living with the legacy of historical trauma, stories provide powerful opportunities to see a bigger picture and embraces strength, honour, and courage. Stories are bonding tools; a story unites people to overcome a problem because everyone identifies or empathizes with the stories and can relate to them. Hearing other people's stories provides hope to the wounded souls. Listening and knowing that the storyteller has gone through the same situation, survived, with wounds and all is comforting. When you understand a story, you connect to it, and the role you play can heal the wounds and focus on the challenges of the present.

It is important to share your story as well as listen to other people's stories. The power of storytelling can break barriers, create hope, bring healing and reconciliation for people. Exploring the lived experiences of urban Aboriginal iskwewak (women), utilizing the personal storytelling with urban Aboriginal iskwewak (women) living with HIV was a compelling experience.

Blending western ka isi kiskenitaman (ways of knowing) and ininiw ka isi totaman (Aboriginal ways of doing), using traditional storytelling, can be powerful tools that connect people, break barriers, and heals wounds. There is a deficiency in the existing literature

regarding Aboriginal methods of healing from intergenerational trauma. However, a few Indigenous scholars are creating research in the area of healing/caring: Nabigon and Mawhiney (1996); Mehl-Madrona (1997) Hart (2002); Wenger-Nabigon (2006, 2010. Another deficiency in the literature is in the study of the resilience of Aboriginal people to promote mino pimatisiwin.

3.5 Deficiencies

There are several deficiencies in the existing literature regarding urban Aboriginal women living with HIV. Listed are several deficiencies I came across during my examination of the existing literature about urban Aboriginal women and HIV:

- A deficiency about food insecurity and how it relates to the urban Aboriginal women living with HIV
- A deficiency in gender-sensitive and culturally specific HIV prevention strategies for Aboriginal women
- A deficiency of Indigenous research with Elder engagement and how trauma plays out in the lives of urban Aboriginal women
- A deficiency in identifying and quantifying the association between social determinants of health and urban Aboriginal women
- A deficiency in exploring the intergenerational effects of Indian residential schools and the IRS survivors
- A deficiency in various methods for healing strategies for intergenerational trauma.

This research project seeks to contribute to the existing literature by highlighting the perspectives of urban Aboriginal women living with HIV, examining some of the deficiencies in the literature. By providing detailed information based on my primary research with urban

Aboriginal women, this project has incorporated more information towards promoting mino pimatisiwin for the urban Aboriginal women living with HIV.

The following chapter outlines the research design utilized to explore the perspectives and lived experiences of urban Aboriginal women living with HIV.

Chapter neyo (Four)

Research Design

4.0 Introduction

This chapter describes the research design, describes the research site and participants, and includes criteria with justification for each criterion. An explanation of the Indigenous protocol before the research project commencing. The data collection and analysis of the stories shared by the participants selected for this research by discussion of trustworthiness, ethical considerations, limitations, and conclusion.

4.1 Research Design

This project utilizes a qualitative design through a case study using an Indigenous relational paradigm. The exploratory nature involves going into a community to explore the relationships of urban Aboriginal women who live with HIV and factors contributing to an increase of HIV among this population.

An Indigenous research paradigm is a framework of a belief system that comes from Indigenous people's lived experiences and history. This theoretical framework assumption, according to Chilisa (2002), promotes “relational accountability that results in respectful, representation, reciprocity and rights of researched” (p. 41).

An Indigenous paradigm, according to Kovach (2010), is based on “Indigenous knowledge, [ka isi kiskenitaman (ways of knowing) also known as] “storytelling circles, yarning, talk story and re-storying” (p. 40). I used storytelling sessions and a talking circle with relational life story interviews to gather knowledge from the perspectives of the nine urban Aboriginal women living with HIV. According to Chilisa (2012), [a talking circle] “relational interview is a life story a person chooses to talk about the life he/she has lived, highlighting the

most important aspects and enables [the researcher] the use of an interview guide...to bring topics that may be absent" (p. 209).

4.2 Role of Research/Storyteller

My role as a researcher is a key instrument in qualitative research, as I collect data by listening to and recording the stories of the women. Creswell states (2014) the "researcher needs to learn about the problem from participants and to address the research to obtain that information" (p.186). My reason for utilizing a qualitative design was to explore and understand the perspectives and challenges of urban Aboriginal women living with HIV and its impact on the women and what factors contribute to an increase in HIV cases. Using the narrative approach, I collected achimowak (stories) from the women about their lived experiences with HIV. Creswell states, "information is then often retold or restored by the researcher into a narrative chronology" (ibid: 14). I explored the impact of HIV on the lives of urban Aboriginal women through storytelling sessions, a talking circle, and relational interviews that allowed the participants to talk about their individual stories freely, as ancient Indigenous ways of sharing knowledge. A case study is an empirical inquiry that Noor (2008) "investigates a contemporary phenomenon within its real-life context using multiple sources of evidence" (p.1602). Case studies are helpful when the researcher needs to understand a particular issue in-depth. My reason for utilizing a case study is that it allowed me to see a holistic view of the issues and generalizations of findings using several cases.

4.3 Data Collection Strategy

This section describes the research site, the purposive sampling inclusive criteria, justification for criteria, and the methodology used for data collection.

4.3.1 Research Site and Participants

Nine Circles Community Health Center is located at 705 Broadway Avenue, Winnipeg, Manitoba:

It is in Treaty One territory, on the traditional territory of Anishinaabe peoples and homeland of the Metis. Nine Circles sits on the crossroads of the Anishinaabe, Metis, Cree, Dakota, and Oji-Cree Nations. Nine Circles' mission statement is: with expertise in the care and treatment of HIV, Hep C, and other sexually transmitted infections, delivers comprehensive primary care, social support, education, and prevention programs-creating healthier communities for Manitobans. Core values are client-centred, developed in partnership, culturally safe, integrated and outcome-oriented. [ninecircles.ca/]

4.3.2 Round Room

This room is circular, and the walls are painted as one complete nature mural surrounding the room. The mural depicts the four directions of the medicine wheel. There are bundles of sage and sweet grass hanging from the ceiling. The scents of sage and sweet grass are in the air when you enter this room, which is a relaxing and safe place for the participants. I had several reasons for selecting this site. I worked as an HIV nurse clinician at Nine Circles Community Health Center for twelve years. Secondly, I have met many urban Aboriginal women in this building and have been in sharing circles with these women at this site. Finally, and the most important reason, I knew this would be a safe and private place for women in this research project. Confidentiality and respect for the women are of the utmost importance within the walls of Nine Circles Community Health Center. I felt NCCHC is the ideal research site for this research project.

4.3.3 Participants

Approximately half of Winnipeg's HIV population, both Indigenous and non-Indigenous, attend the medical clinic at NCCHC. My research aimed to explore the experience of living with HIV according to the perspectives of urban Aboriginal women.

To obtain the purposive sampling I required for this research project, I advertised by placing posters of the research project in public areas at NCCHC for two weeks.

The purposive sampling inclusive criteria:

1. self-report as Aboriginal (of any nation) women who have been diagnosed with HIV

2. lives in Winnipeg, Manitoba; and is

3. age eighteen years or older

The term Aboriginal includes women who identify as Metis, Inuit and Indian. The sampling size will be between six to ten urban Aboriginal women.

My rationale for this purposive sampling criteria selection was thus. Knowing that HIV is increasing among urban Aboriginal women, I wanted to explore the risk groups of HIV and explore risk situations among Aboriginal women while moving away from the epidemiological focus on HIV.

I applied the nistam (first) and niswayek (second) criteria as the focus of this research project was Aboriginal women living in Winnipeg, Manitoba. According to Becker (2012), "more than 43 percent of Canadian Aboriginal population live in three prairie provinces of which Winnipeg, Manitoba having the largest urban Aboriginal population which accounts for thirty percent of HIV cases and one third were female …18-39 years of age" (p. 19).

4.4 Data Collection

4.4.1 Introduction

The following section describes the traditional protocol done before the research, the data collection method, the timelines of the data collected and ethical considerations.

4.4.2 Creating an ethical, safe space for Indigenous research

As a researcher, it is my ethical responsibility to create an ethical, safe space for this Indigenous research project. In many Aboriginal cultures, when events occur, a pipe ceremony is performed by an Elder before commencing the event. persons as individuals and social beings" (p. 60).

Wilson (2008) states that "research is ceremony," and Kovach (2009) cites Cree Elder Wiona Stevenson (2000. p.19), stating, "I believe it to be true," This articulates to me that we need to develop a relationship with our research in order to be "authentic or credible …to accurately reflect on the relationships between ideas and participants, true to the voices of all participants and reflect on the understanding of the topic and [reflecting having created validity, dependability] "relational accountability" (Wilson 2008p. 102). Ways that I created relational accountability and validity was by using ininiw ka isi kiskenitaman ekwa ka isi totaman (Cree ways of knowing and doing) and requesting an Elder perform a traditional pipe ceremony for the research and participants, and by introducing myself in Cree to tell participants who I am and where I come from, and by reflecting on my lived experiences in telling my story. My approach created an ethical, safe, and sacred space for the iskwewak (women) to tell their stories.

Although this research is not about me, self-positioning in my research is critical. Introducing myself, stating who I am and where I come from builds trust and respect with

relationships. These values are essential in Indigenous life and research. I refer to my research as a story and myself, a storyteller. As Wilson (2008) states [when doing Indigenous research with Indigenous people] "the use of an Indigenous research paradigm requires holistic use and transmission of information [and the participants and researcher take] the role as storyteller. [As] Indigenous people in Canada recognize it is important for storytellers" (p. 32) to tell their own story, allowing the women to relate to the story and what is significant in their lives. Using story creates a space for authentic Indigenous research and builds on the relationship of researcher/storyteller and participant/urban Aboriginal women. Wilson argues that the "foundation of Indigenous research lies within the reality of the lived Indigenous experience of real people**"** (ibid: 60); therefore, Indigenous research is grounded in people's lives.

One ka isi totaman (way of doing) in creating a relationship with urban Aboriginal women is by self-positioning or centring myself in the research.

4.4.3 natinamakewin achimowin (sharing my story) self-positioning

tanisi nitisinihkason paskwawimisostos iskwew nitohcin ochek sipihk ininimowin. (Hello, I am Buffalo Woman, and I come from Fisher River Cree Nation.) I introduce myself with my spirit name as a way of claiming my Cree identity and to acknowledge the spirit of the paswawimistos (buffalo) who guides me in my daily journey. Introducing myself in Cree reminds me of who I am, where I come from, and my responsibilities of upholding the teachings that have been shared with me by the Anishinaabe, Dakota, and Cree Elders.

4.4.4 Preparation before Research Project

I met the resident Elder of Nine Circles Community Health Center and the potential participants to develop relationships. According to Baskin (2005), a primary value of Aboriginal culture is “relatedness” (p. 179). I explained the ceremony done by the Elder and

informed the participants that if they were uncomfortable with this, they do not need to participate. My approach allowed each participant to get to know and trust me. I explained the research process and what happens with the information collected. I asked each participant their opinion of the research topic. By listening to their opinions, according to Carjuzza (2010), I participated in "respectful research that addresses cultural standards of the community and a repositioning of the researcher from interpreter to listener with an openness to learning from Indigenous perspectives" (p. 6).

4.4.4.1 Requesting help from an Elder

As per traditional protocol, I offered tobacco with good intentions and respectfully to the Elder of Nine Circles Community Health Center, asking for their guidance and wisdom throughout the research process. I offered tobacco to the potential participants, asking them if they would take part in the research project. Anyone can refuse the offering of tobacco if they are not comfortable taking part in the research project.

Requesting assistance from an Aboriginal Elder requires planning. Elders have other responsibilities and commitments to other clients, much as a Western counsellor or doctor. Being respectful of their time, one needs to set up some time to get acquainted with the Elder, usually over a cup of coffee or medicine tea. This approach allows the Elder to listen to your story and consider your intentions. In my experience, the Elder does a pipe ceremony with your tobacco after your visit. This ceremony allows the Elder to consult with their spirit guides and decide whether they can offer you guidance in your request.

4.4.4.2 Pipe Ceremony and Feast

Before the storytelling/interview sessions, the Elder of Nine Circles Community Health Center performed a pipe ceremony, as per traditional protocol. The tobacco was accepted

previously, a sign of oral consent, and the Elder signed a written informed consent form for the protocol for ethics. Participants could not attend this event due to previous commitments, but I invited the community present in the building for the feast. Performing the traditional preparation for this research project, done with good intentions and a good way, created a sacred, safe, and ethical space for the participants to share their stories. The ka isi kiskenitaman (ways of knowing) ekwa ka isi totam (and ways of doing) have been shared with us by our Elders' sacred stories and teachings.

I described the pipe ceremony before starting the research. As Wilson (2008) and Chilisa (2012), state "Indigenous research is ceremony" (p.221) and a sacred process. My description of the ceremony was also an acknowledgment to the Elder and the participants.

As with any important event, the Elder conducted a pipe ceremony for the participants and the research project. The sacred teachings of humility, truth and respect are intertwined into this ceremony. The Elder asked the Grandmothers to help with their wisdom, help us respect each other and the relationships formed, help us be humble, and be truthful to ourselves. After the ceremony, there was a little feast. Like the offering of tobacco, this is the protocol that needs to be followed. The feast gives thanks to the participants. A spirit dish (small amounts of the food) was made and placed in a safe, clean place outside to give thanks to the spirits for their help. According to Baskin (2005), the "giveaway is another aspect of Aboriginal worldview, symbolizing balance, the process of give and take, reciprocity and a gesture of thanksgiving" (p. 18). Before beginning the research process, all this protocol is vital as it strengthens and helps the participants, especially when sensitive topics are shared.

4.4.4.3 Conclusion

The traditional protocols prior to doing Indigenous research created an ethical sacred, safe place for the participants.

4.5 Research Objectives

4.5.1 Storytelling Sessions

On October 25, November 1 & 8, 2018, I initiated the storytelling sessions from 1000-1400 hours in the round room at Nine Circles Community Health Center. I had offered to do a sharing circle for the women. However, the women opted for individual interviews, which I honoured. I introduced myself, offered tobacco to all traditional women, who accepted the tobacco as agreeing to participate in the research, explained the purpose of the interviews, read the description of the study form, the participant informed **consent signed by all (nine) ten women**. A copy of the signed informed consent was given to each woman. Six women agreed to have their names published in the findings. **I listened and audiotaped all nine Aboriginal women** as they shared parts of their lives in the first neso (two) sessions. Two questions were designed to fulfil each of the following objectives. (Appendix C).

4.5.1.1 Objective peyak (one): To explore the perspectives and lived experiences of the urban Aboriginal women living with HIV.

4.5.1.2 Objective niswayak (second): To describe the challenges and realities of living with HIV, according to the perspectives of the urban Aboriginal women.

I had two storytelling sessions using focussed life-story interviews with the women. Chilisa (2012) states that this "method of interview that brings to the discussion, ways that allows relational ways of knowing to enable the use of an interview guide" [in which the

participants] “are connected to one another and to the environment” (p. 208). Chilisa continues to say this type of interview is “very appropriate for sensitive topics” (ibid: 210).

The life story interview allows for a narrative style, and allowed me as the researcher to listen, probe and bring up topics that need to be discussed. According to Kovach (2009), a life story is associated with studying the totality of a person's life. As the women share their life stories, it is a "means that gives voice to the marginalized" (ibid:96), providing insight to create outcomes for the stories related to the women's needs.

I collected the nine women's data (life stories), documenting the reactions and feelings as they shared their stories in a research journal using an observational protocol. This technique of observing allows the interviewer to see firsthand experience with the women and is helpful to explore topics that may be uncomfortable for participants to discuss. I transcribed all data collected into my research database to ensure confidentiality.

The reason for using a storytelling session, an ancient Indigenous method, is based on niso (two) of the seven sacred teachings, respect, and truth. The principles of a storytelling session are respect for everyone by listening to each other and not interrupting when one is sharing. Storytelling sessions, according to Baskin (2005), is a "valid form of Aboriginal knowledge as it includes the responsibility of listener/researcher, incorporating, both interpretation, analysis and explanation for the phenomena of being researched" (p. 180). According to Kovach (2009) 'stories are who we are" (p. 108), and sharing one's life story is sacred. As researchers, we need to be accountable and responsible to keep the knowledge shared confidential.

I utilized a semi-structured interview and developed a focussed life-story interview guide, starting with a general question followed by probes and discussion questions. According

to Chilisa (2012), this "allows for the flexibility and makes it possible for researchers to follow interests and thoughts of informants" (p. 205). The focussed life-story interview gives the women the ability to choose what they share about their life as honestly as possible.

4.5.1.3 Objective nistwayak (third): to promote mino pimatisiwin (health and well-being)

Utilizing a talking circle, I collected information from the perspective of the women on what would help them seek health and well-being. The talking circle is an ancient and culturally appropriate method used by numerous Indigenous peoples. According to Struthers (2003), a “talking circle is used to teach culture and tradition and can be used in health education and promotion” (p. 1095). Chilisa (2012) states that talking circles "symbolize and encourages sharing of ideas, respect of each other ideas and togetherness for each other" (p. 213).

I collected demographic data such as age when the participants were diagnosed with HIV using survey questions before the storytelling session. I used a research journal to record the date, site, participant sharing, secondary materials, interview questions, and probes for follow-up questions for more detailed information if needed. I gave each of the women my contact number if they need to contact me with some information they did not discuss in the storytelling sessions. With their permission, I could add this data to the data collection. I offered private space for the women if they did not want to partake in the talking sessions. In this situation, I would use the same life-story method of an interview to share with the individual(s).

4.6 Ethical Considerations

Before proceeding with this research project, ethical approval was sought and received from the Research Ethics Review Board and the Department of Indigenous Studies, University of Winnipeg. I also requested and gained permission from the Executive Director and the board

of Nine Circles Community Health Center to use the round room at NCCHC as my research site.

The ethical principles of respect, confidentiality, and justice were ensured in the following ways. As a researcher, I am responsible for ensuring that the women were well informed about the research purpose. They also needed to understand the risks and benefits they may encounter as part of the research. The women need to be able to make an independent, informed decision without fear of negative consequences. An important consideration to avoid ethical issues is using an informed consent form throughout the research process. Another way of avoiding ethical issues is being honest about positioning oneself in the research, who I am, where I come from, what and why I was doing this research and what I was doing with this information collected.

I anticipated sensitive issues by arranging referral services or crisis management for the women. I planned for an Elder to be present in the building to give moral support. I contacted the councillor of NCCHC to be on stand-by in the event a crisis occurred. I would have stopped the research, called the councillor, and reported the incident to the research board if a crisis happened. Fortunately, no crisis occurred during the three sessions with the women.

I explained confidentiality to the participants before the start of the research project. I ensured field notes and transcriptions did not contain personal identification and kept written data under lock. I stored electronic data with a password. I respected the study site during the research process, which helped build trust and relationships with the facility staff.

The principle of doing no harm was achieved by being honest and not exploiting the participants during the study by focusing on the research questions stated in the interview

guide. I provided little gifts such as honoraria for the women taking part in the project. When analyzing data, I respected the women's privacy by disguising their identities in the data. I used multiple perspectives, reported contrary findings, and shared the findings with the women and the advisory group for the project.

When reporting, sharing, and storing data, I used Creswell's (2012) "APA guidelines for permission needed to report and adapt work of others" (p. 94). I was honest and used unbiased language suitable for the audiences of this research. I provided copies of findings for all participants, stakeholders. I acknowledged ownership of data to researcher partnership and advisories, disclosed any conflict of interest and disclosed information of funders for this research project. At the completion of my research project, a little feast, giveaway, and sweat ceremony were done for the Elder and the women to show my appreciation and to thank everyone for their contributions to the project.

4.6.1 Role of Researcher/Storyteller

The role of the researcher is the key instrument in qualitative research. Due to previous experience with Nine Circles Community Health Center, I brought certain personal biases and values. Even though I made efforts to ensure objectivity, my biases may affect how I viewed and understood the collected data. As my role of researcher/storyteller, and according to Chilisa (2012), I used the 4 R's "accountability, responsibility, respect and reciprocity for the rights and regulations of the researched" (p. 7). I used the principles of OCAP (ownership, control, access, and possession) in my research as they may convey significant benefits for Aboriginal health agencies, communities and governments and the Aboriginal communities. I also accessed the advice from the advisory group for my research project, two female Elders, who would bring an unbiased view and input to the project.

4.7 Data Analysis

Data analysis is an ongoing research process involving organizing the data collected, coding, and looking for patterns that emerge as themes. According to Creswell (2018), citing Reissman notes that narrative analysis "refers to the family of methods for interpreting texts that have in common a storied form" [and consists of] "describing the story into a chronology and locate the turning points" (p. 198).

This section describes in detail the treatment and analysis of the results of the stories of the participants. Looking through an Indigenous lens, I gathered and examined a new bundle of Indigenous knowledge or stories of the nine Aboriginal women who live with HIV.

4.7.1 Methods

I used the Cree medicine wheel, grounded with the perspectives of the nine urban Aboriginal women's lived experiences, to place the emerged themes in the appropriate quadrant, according to the life cycle of human development. The data was re-storied, analyzed by coding the findings, and themes were retrieved from the data. At this point in the process, I shared the preliminary findings with the participants to ensure the validity of the data and continued throughout the data analysis process.

According to Creswell (2012), narrative research uses a method of analysis described as “restoring the participants stories using structural devices such as plot, setting, activities, climate and denouncement” (p. 196). I focused on the women's experiences and the construction of their life stories based on data collected through interviews. I emphasized the women's collaboration on chronologically constructing the re-story of each woman. I compared the themes to the existing literature for confirmation or deviation from the literature.

4.7.2 Process

4.7.2.1 Transcription

The analysis process for this research project follows Creswell and Poth's (2018) outline for qualitative data analysis. Once the recorded life story interviews were completed, I did a cursory review of all nine audiotapes before transcribing to check for clarity and accuracy.

4.7.2.2 Coding

I conducted a thorough reading of raw data, organizing the data for detailed analysis.

1. First level coding - studying the interviews looking for patterns
2. Second level coding- identifying themes and (Creswell 2014) "interconnected the themes into a storyline (p. 200).

4.8 Establishing Trustworthiness

This section is a discussion in developing trustworthiness and accuracy of the project throughout the research process by using through validation strategies:

4.8.1 Participants' Lens - Member checking or seeking participant's feedback.

Participants play an essential role in qualitative research in the validation of the data analysis. I gave the women a draft copy of the preliminary analysis Creswell (, 2018) to "reflect on the accuracy of the account and listen to their views of the written analysis for practical guidance on interpretation" (p.262). I shared the findings with the participants to validate (member checking) for data accuracy, which allowed them to comment on the findings.

4.8.2 Researcher's Len's

For triangulation, I collected multiple sources, i.e., interviews, storytelling, then compared them to build an accurate picture or interpretation of the data. To clarify bias, I

commented on how my interpretation of the findings was affected by my culture and background; this self-reflection made for an honest narrative. I used a triangulation strategy to ensure trustworthiness or reliability by comparing data from one method, such as life stories, to data from talking circles and the literature review.

4.8.3 Reader's Lens

1. External audit: Getting a person not involved in the study to review and ask questions regarding the study added validity to the project. Using an external investigator to look over the entire project can provide an objective assessment of the study throughout the entire research process and ultimately increases the validity and reliability of the research project.
2. Generating Chilisa (2012) "deep description": giving a deep, rich description of the research project and participants allows for the possible transferability of the findings to another research site to determine whether it is transferrable.

4.8.4 Transferability

To enhance the transferability of the research study, I selected clients who lived with HIV and were somewhat knowledgeable about HIV. Selecting homogenous sampling, according to Chillisa (2012) in "where selected participants are very similar in experience, perspective, or outlook" (p. 170), would increase the transferability and "specific to the needs of the study (Chillisa: ibid).

With the validation strategies, this qualitative project seeks to understand a body of knowledge generated by the women. Spending time with the women and probing to find detailed meanings creates accuracy, credibility, reliability, and trustworthiness.

4.9 Conclusion

This chapter outlined the research design and methodologies for this research project. The design and participants were described, including the methods of data collection. I also outlined the analysis process, as well as my approach to validation and trustworthiness. I describe the findings of this research project in the following chapter.

Chapter niyanan (five)
Findings and Discussion

5.0 Introduction

In this chapter, I provide the findings and discussion of this research project. The findings are grounded in the lived experiences of nine urban Aboriginal women.

Limitations of the Study

One limitation of this research project is the sample size. Nine Aboriginal women shared their stories in this research project. Due to the limited time to complete the project, the sample size needed to be manageable for a master's thesis, therefore a smaller sample size.

5.1 Demographic Data

I interviewed nine Aboriginal women who live with HIV. All nine women utilized NCHC as a place to seek medical care. The ages of the participants ranged from 23 to 60 years. One woman was diagnosed when she was fifteen, two at seventeen, three women in their twenties, one in her thirties, and two in their fifties.

I organized the themes that emerged into the four quadrants of the medicine wheel - physical, mental, emotional, and spiritual. The themes were based on my interpretations of the raw data during the data analysis:

5.2 Findings

5.2.1 Physical

5.2.1.1 Financial issues

All nine women are living on social assistance. Limited financial resources created food insecurity for all nine women. They all utilize food bank services. The women that purchase drugs are affected with further financial issues, which lead to poverty. One woman shared that

transportation to doctor appointments was a problem, "no money for bus tickets." Two women shared housing was a problem as they were "couch surfing."

5.2.1.2 Sexual abuse

Three women disclosed that a family member sexually abused them during their childhood and adolescent years. They also shared that their parent(s) went to residential school. One participant shared that “she was raised in a foster home from age six to sixteen years only to ran away to find her mother." Another woman shared that she ran away from her home and was "pimped out by men at fifteen. Another woman shared that she used to work the streets at one point in her life.

5.2.1.3 HIV medication

Two women shared that taking HIV medication was an issue; “forgetting to take the pills because they are "drinking and drugging" too much. One woman shared that she "stopped taking HIV medication because of unstable housing."

5.3 Emotional

Some of the women's comments when they learned of their HIV positive test results: "I was mad and sad," "I was ashamed, scared," "I was shocked when I learned of my HIV status." All the women experienced different stages of grief resulting from the diagnosis of HIV.

One woman shared that she started using alcohol at age thirteen because of peer pressure and to cope with the fact that her stepfather "would try to get into bed with her when she was living at home." She goes on to say that she "started school at St. Benedict's School to get away from her stepfather." One woman shared that "she started intravenous drugs due to peer pressure and to escape from the reality she had HIV." Seven of the women shared that they "smokes marijuana to make themselves feel good." One woman started using alcohol after her

spouse and unborn child died. She shared that she "drank alcohol every day for a while" to cope with her losses. Two of the women starting using alcohol to cope with the trauma of sexual abuse.

5.3.2.1 HIV stigma

HIV stigma among people was an issue with all the women. The women shared they were "careful who they shared their HIV status with" because 1) one woman stated, "I am afraid that people will talk about me if they know I have it." 2) one woman shared that people don't share drinks or cigarettes with her because of her HIV status. This also reveals a lack of HIV education among other people. 3) one woman shared that she "was treated differently by women's shelter staff when she disclosed her HIV status."

5.3.2.2 Loss of cultural identity

Eight of the women do not speak their Aboriginal language. The one that spoke her language had no one to "talk her language with." Six of the women have never attended any cultural ceremonies.

5.3.2.3 Unresolved grief

One woman still deals “with the loss of my husband and child even though they died in the 1980’s.” The two women that identified themselves as “I am HIV” can be struggling with the diagnosis of HIV and have not completed the grieving process.

5.3.2.4 Social isolation

Several women shared they felt “isolated because of their HIV status” They felt afraid to go to social events in case there was someone there who knew their HIV status and would tell other people. Four of the women shared that they felt "excluded" from their families after disclosing they were HIV positive.

5.4 Mental

5.4.1 Lack of information on HIV transmission

All the women shared that they did not know much about HIV transmission before their diagnosis. Two women shared that they had contracted through HIV+ partners. Two women shared that they "shared needles, not knowing that sharing needles was a method of HIV transmission." One woman thought that "HIV was a gay man's disease."

5.5 Spiritual

The spiritual aspect of human development is a "learning and healing process" (Hart 2002 p. 85-89). Two women follow the traditional Aboriginal way. One attends sweats, sun dances, and other ceremonies. These two women have stopped drinking and doing drugs the majority of the time. One woman started attending ceremonies to "find herself and help her cope with having HIV. Two women shared that they "would like to go to sweats and sharing circles." However, due to lack of transportation and lack of updated information about events, they cannot go.

One woman advised, "stay positive, try live day to day. Keep living, enjoy life every minute while we can." This woman attends traditional ceremonies. Two women shared, "be healthy, go to traditional ceremonies."

5.1 Discussion

5.1.1 Introduction

This section summarizes the purpose, research questions, literature review, findings, and discussion.

The initial purpose of this research project was to explore the lived experiences among Aboriginal women in Winnipeg, Manitoba. I achieved this by recording life story interviews,

conducting a literature review, and discussing the research with local Elders. I sought to 1) to explore the perspectives and lived experiences of Aboriginal women living with HIV who reside in Winnipeg. 2) to describe the challenges and realities of urban Aboriginal women living with HIV and 3) to promote mino pimatisiwin.

5.1. Discussion

The findings reveal that all aspects of human development - physical, mental, emotional, and spiritual-affect the women in this study. The social determinants of health are essential factors that impact urban Aboriginal women's physical and mental well-being. My findings also revealed the impact of the Indian residential school experience on the study participants.

According to Anderson (2019), the Indian residential schools "promoted family separation and cultural dissociation during childhood and adolescence" (p.379). Childhood and adolescence are critical stages of health development that "determine cognitive and social capacity of life in early adulthood and beyond" (ibid:379). The Indian residential schools not only "caused health inequalities but also intergenerational trauma" (ibid:379). The residential schools "instigated the dissociation of spiritual and cultural cohesion within the Aboriginal communities" (ibid:379). Anderson describes a study revealing that "76.8% of students recognised a significant loss in cultural identity due to their residential school experience" (ibid:379). Children in the residential schools were not allowed to speak their language or practise their cultural ceremonies. The Canadian government forced Aboriginal children to learn Euro-Canadian culture. Anderson goes on to state that "childhood and adolescence are vital times of cognitive learning and relationship maturation" (ibid:379) where a child accessing quality education "is a protective factor for the future health status because it promotes

academic and social skills development, increase health literacy and enables positive interpersonal development" (ibid:379).

Accessing quality education is only possible with caring, supportive resources, which was not the case in residential schools. Children were forced to leave their families for long periods. Kim notes that "family separation in childhood has been shown to be a major risk factor for mental disorders such as depression" (ibid:379). In my study, several of the women who attended residential school experienced depression at some point in their life. Aboriginal people consider cultural practices as part of health. Not being allowed to participate in cultural practices was considered a loss of health. Forbidding Aboriginal cultural practices was accompanied by verbal abuse from the teachers who shamed the children for their beliefs and practices. Anderson states, "childhood abuse has been linked to poor health, leading to increased hospitalizations for physical and psychological illnesses in adulthood" (ibid:379). The residential school system was abusive and a detriment to the Aboriginal population. The negative experiences of Aboriginal children who survived the Indian residential schools have been passed on intergenerationally.

The life stories of the nine urban Aboriginal women had several similar characteristics. Some of the women had unstable housing; they couch surfed. All the women used substances, alcohol, drugs to cope throughout their lifespan. Many of the women experienced strained family relationships. Several of the women experienced the trauma of emotional and sexual abuse by a family member. Two women shared that they ran away from home as a teenager. One ran away from a sexually abusive stepfather. Shahram's (2016) study states that substance use among Aboriginal women is "rooted in the social determinants of health" (p.158). The findings of this study are consistent with Shahram's study, where my participants reported using

substances as a coping mechanism to deal with emotional and sexual abuse. The findings are also supported by various authors cited in the literature review.

I argue that Aboriginal women living in the inner city of Winnipeg are the most disadvantaged people and most challenged relating to poverty. Poverty is one of the social determinants of health that is the most significant issue facing urban Aboriginal women. To build my argument that Aboriginal women are the most disadvantaged people, I examined the socioeconomic conditions of these women. The social assistance income (Government of Manitoba) for one person in Winnipeg is $877 per month. To survive, some women tend to participate in sex work which leaves them at risk for HIV transmission.

Gorkoff and Runner (2003) argue that money, needing drugs, and basic needs were the primary motivator for working the streets and "survival sex is the sale of sexual services by those such as homeless youth and women in poverty who have few other options" (p. 33). Many of the homeless young female youth ran away from abusive home environments or foster homes. In the Gorkoff and Runner study, of the forty-five participants, "a higher percentage were of Aboriginal descent (26 or 57.7 percent) than Caucasian (19 or 42.2 percent)" (ibid; 24). The women in this study were from the three prairie provinces, the average age was from eighteen to thirty-six years of age, and approximately three-quarters of them involved in survival sex started at age fifteen.

The authors mention that many of the women talk about the "emotional distress and physical ill health" (ibid;95) in their lives resulting from their lifestyle, with low self-esteem, depression, and disregard for their protection from transmission of sexually transmitted infections, including HIV. Precarious socioeconomic conditions and the continuous emotional stress and ill-health of the Aboriginal women, according to Gorkoff and Runner (2003), create

"social stigma" (p. 19). This social stigma prevents many women from seeking assistance from professional services resulting in a downward spiral of poverty, ill-health and increasing the risk of HIV transmission.

Poverty contributes to urban Aboriginal women's vulnerability to HIV and worsens the impact of HIV for these women. Therefore, this relationship between HIV and low-income for urban Aboriginal women leads to further poverty, such as food insecurity.

Food insecurity is a characteristic of poverty and a barrier to the health of urban Aboriginal women living with HIV. According to Anema (2009), an operational definition of food insecurity is the "limited or uncertain availability of nutritionally adequate, safe food or the inability to acquire personally, acceptable food in socially acceptable ways" (p. 224). Food insecurity is linked to increased susceptibility to HIV due to increased malnutrition rates in people who live with HIV. Food insecurity has been linked with incomplete viral suppression of HIV, where some of the antiretroviral medications need to be taken with food for maximum absorption in the body. Food insecurity is also associated with non-adherence to taking antiretroviral medications by people who live with HIV, causing a rapid HIV disease progression and increased mortality.

The National Population Health Survey (1999) reported that "24.1% of respondents did not have enough food and the prevalence of food insecurity for low income First Nations women in Winnipeg not able to choose food on the basis of its cost" (p. 1). This food insecurity attributes to the risk of ill health for urban Aboriginal women. Current dietary practices of Aboriginal women pose health risks and decrease the quality of life. The existing literature is deficient concerning determinants of food security for urban Aboriginal women living in

Winnipeg, Manitoba. Anema (2009); Duncan (2011); McCall (2009); Mignone (2007); Weiser (2009).

There is limited literature on HIV prevention strategies and implementation that meet the cultural needs of urban Aboriginal women. Current HIV prevention strategies do not appear to be effective for urban Aboriginal women based on the evidence in the increase of new HIV-positive cases in urban Aboriginal women in Winnipeg. Manitoba.

Research is needed into the how and why HIV risk situations occur among urban Aboriginal women. According to McCall (2009), HIV is a "social problem that requires a social solution" (p. 1778). Solutions will come only when all are equals in our society. Wesley-Equimaux (2009) argues that Aboriginal peoples need "to regain our social agency" (p.30). To rephrase Wesley-Equimaux's quote, we need to reclaim the traditional roles and responsibilities of the iskewew (women).

Traditionally, Aboriginal iskwewak (women) are the life-givers. Boyer (2009) notes that iskwewak "were the keepers of traditions, practices and customs of the nation" (p. 70) and were held in high respect. Their voices were heard when important decisions were being made. The traditional roles of iskwewak (women) need to be reclaimed to restore the balance in Indigenous society. Society can learn from the knowledge keepers, the urban Aboriginal women living with HIV, incorporating cultural aspects in HIV care. Bucharski (2006); Flecker (2006); McCall (2009); McCall (2014).

5.2 Conclusion

The literature and the findings of this research project reveal the association between socioeconomics, political and historical factors, the social determinants of health, and the incidences of HIV in this population. Urban Aboriginal women are vulnerable to the

intersecting risk of HIV, violence, and poverty. Due to social and economic challenges, as evidenced by the findings, some Aboriginal women turn to survival strategies, which risk HIV transmission. There is a relationship between the challenges that urban Aboriginal women face with the historical impact of colonization.

Colonization has stripped the traditional roles of Aboriginal women by enforcing patriarchal views. The residential school system has destroyed the cultural identity of Aboriginal students that attended. Without any cultural values to guide them, students became a lost generation. With the trauma from losing their culture, many women turned to drugs and alcohol to hide their pain. This understandable reaction can cause a downward spiral, where the women become vulnerable to risk situations.

To restore mino pimatisiwin (a good life), Aboriginal women need to regain balance in a holistic manner- all aspects physical, emotional, mental, and spiritual. There is limited literature on traditional helping programs. Health care organizations need to utilize traditional tools to support their Aboriginal clients. The medicine wheel framework needs to be conceptualized and utilized by health care providers, addressing some inequalities and challenges urban Aboriginal women living with HIV face. As urban Aboriginal women become more aware of the root cause of the inequalities, they can start their healing journey. Aboriginal women can empower themselves by learning about colonialism and share their education with the public. There is a clear need for public health education in schools to promote HIV awareness.

5.3 Suggestions

The section contains suggestions that emerged from the talking circle of nine Aboriginal women:

1. transportation for ceremonies and workshops
2. more access to traditional ceremonies
3. more culturally appropriate HIV prevention programs
4. further research on HIV and Aboriginal women
5. workshops for schools on HIV education

5.4 Recommendations

1. culturally appropriate educational training for health care providers on the history of the Indian Act, Indian residential schools, and colonization
2. incorporate this same information in medical, nursing, social work, and police training
3. develop culturally appropriate HIV prevention programs
4. further research is needed on HIV and urban Aboriginal women
5. implement Indigenous research methods and ways of knowing into research projects.

I have highlighted some of the disparities of the urban Aboriginal women living with HIV. Based on the existing literature and findings, there are several knowledge gaps on HIV as experienced by Aboriginal women. Further research is needed on the social determinants of health and the Aboriginal women living with HIV in Winnipeg, Manitoba.

References

Adelson, Naomi. (2000). *"Being Alive Well" Health and Politics of Cree Wellbeing.* University of Toronto Press.

Anema, A., Naphthalene. N., Froggin. E. A., Kalevala. S., Wiser. S. D. (2009). Food Insecurity and HIV/AIDS Current knowledge, gaps, and research priorities. *Current HIV/AIDS Reports. 6* (4), 224-231.

Anderson, Kim. (*2011*). *Life Stages of Native Women. Memory Teaching and Story Medicine.* University of Manitoba Press.

Anonymous, Nehiyawak (Swampy Cree) proverb, http://www.scc.sk.ca/archive/heritage/our/languages/swampy/elders/quotes/index.html. Retrieved July 22, 2018.

Archibald, Jo-Ann. Q'UM Q'UM XIIEM. (2008). *Indigenous Storywork Educating the Heart, Mind, Body, and Spirit.* UBS Press. Vancouver, Toronto.

Baskin, C. (2005). Storytelling Circles: Reflections of Aboriginal Protocols in Research. *Canadian Social Work Review*, 22.2. 171-178.

Batille, Gretchen M., Sands, Kathleen Mullen. (1987). American Indian Women Telling Their Lives. Lincoln and London. University of Nebraska Press.

Battiste, Marie. (2002). Indigenous Knowledge and Pedagogy in First Nations Education A Literature Review with Recommendations. Prepared for National Working Group on Education and Minister of Indian Affairs, Indian and Northern Affairs Canada Ottawa, ON.

Becker, M., Kasper. K. (2012). Characterizing the HIV epidemic in the prairie provinces. *Canadian Journal of Infections, Medicine Microbiology*, 23 (Spring 1).

Bingham, B., Leo, D., Zhang, R., Montaner, J., Shannon, K. (2014). Generational sex work and HIV risk among Indigenous women in a street-based urban Canadian setting. *Culture, Health & Sexuality*, 16 (4), 440-452.

Bombay, A., Matheson, K., Anisman, H. (2014). The intergenerational effects of Indian Residential Schools: Implications for the concept of historical trauma. *Transcultural Psychiatry.* Vol. 5(3). 320-338.

Bourassa, C; McKay-McNabb, K.; Hampton, M. (2004). Racism, Sexism, and Colonization: The Impact on the Health of Aboriginal Women in Canada. Canadian Women Studies. Vol.24(3). 23-29.

Bucharski, D., Reutter. L. I., & Ogilvie. L. D. (2006). "You need to know here where we're coming from. "Canadian Aboriginal women's perspectives on culturally appropriate HIV counseling and testing. *Health Care for Women International*, 27 (8), 723-747.

Buck, Wilfred (2008). Atchakosuk: Ininiwak Stories of the Stars. *First Nations Perspective.* Vol. 2 No. 1, 71-83.

Burrows, John. (2006). *Indigenous Legal Traditions in Canada.* https://w.w.w.openscholarship.wusti.edu/law_journal_law_policy/vol19/iss1/13./.

Borrows, John. (2013). Aboriginal and Treaty Rights and Violence against women. Osgoode How Law Journal. Volume 50 Issue 3 (Spring 2013).=

Campbell, Mae Louise. (2019). Opening ceremony at screening of documentary on Missing and Murdered Women, 1200+. Winnipeg. March 4.

Carjuzaa, J. (2010). The Give Away Spirit: Reaching a Shared Vision of Research Relationships. *Journal of Educational Controversy,* 5.2.4.

Crampton, Linda. (2014). Foxgloves Beautiful Flowers and Digitalis Health Effects. CAMA Publications. Toronto. 61-72. https://owlocation.com>STEM>Botany.

Cree Elders, (2015) Ochekiwi Sipi Cree Dictionary. Publisher. Manitoba First Nations Resource Center.

Cree Legal Traditions Report (2014). https://w.w.w.cerp.gouv.qc.ca/fileadmin/Fichiesclients/Documents...a.../P-267.pdf.

Chilisa, B. (2012). Indigenous Research Methodologies. California. Sage.

Creswell, J. (2014). Research Design: Qualitative, Quantitative, and Mixed Methods Approaches: California. Sage.

Czyzewski, Karen. (2011). Colonialism as a broader Social Determinant of health. *The International Indigenous Policy Journal.* Volume 3 Issue 1. Health and Well Being. http://w.lib.uwo.ca/upj.

Dapice, A. (2006). The Medicine Wheel. *Journal of Transcultural Nursing*.17.3. 251-260.

Datta, Ranjan. (2017). Traditional storytelling: an effective methodology for Indigenous research and its implications for environmental research. AlterNative. 1-10. Sagepub.co.uk/journalsPermissions.nav. DOI:10.1177/11177180117741351.

Dingwall, C., De Leeuw. S., Evans. M., Krause. M., Ward Burk. B., West. V. (2016). *Urban Aboriginal Research Charter Template: A Guide to Building Research Relationships*. University of British Columbia. Community Engaged Research Press.

Douville, Victor. (2008). For Lakota traditional Astronomy is key to their Culture's Past and Future. *Global Press Journal.* February 9, 2018. http://w.w.w.globalpressjournal.com.

Duncan, K. C., Reading. C., Borwein. A. M., Murray. M. C., Palmer; A. W. Hogg. R. S. (2011) HIV incidence and prevalence among Aboriginal peoples in Canada. *AIDS and Behaviour*. (1). 214-227.

Evans, K. (2008). Healing Through Storytelling. *Psychology Today.* March. 2018. http://www.mindful.org/mindful-healing-storytelling

Evans-Campbell, (2008). Historical Trauma in American Indian/Native Alaska Communities: A Multilevel Framework for Exploring on Individuals, Families, and Communities. *Journal of Interpersonal Violence*. 2008. 316-338.

Ferrer, Claire. (1995). Star Clocks: Apache Ceremonies Timing. *Readings in the Aboriginal Studies* Volume 3: Worldview. Samuel W. Corrigan. Ed. Bearpaw Publishing. 108-121.

For the Cedar Project Partnership, Pearce. M. E., Christian. W. M., Patterson. K. Norris. K., Moniruzzaman, A., Spittal, P. M. (2008). The Cedar Project: Historical trauma, sexual abuse and HIV risk among young Aboriginal people who use injection and non-injection drugs in two Canadian cities. *Social & Medicine,* 66 (11), 2185-2194.

Graham, H., Stamler. Lynnette. (2010). Contemporary Perceptions of Health from an Indigenous (Plains Cree) Organization. (NAHO) people living with HIV/AIDS in urban and peri-urban settings. *Prevention. Science*, 12 (3). 324-33.

Goforth, S. (2007). Aboriginal healing methods for residential school abuse and intergenerational effects: A review of the literature. *Native Social Work*. 6. 11-32.

Hart. Michael Anthony. (2002). *Seeking Mino-Pimatisiwin: An Aboriginal approach to Helping.* Fernwood Publishing. Halifax.

Hart, Michael Anthony. (2010). Indigenous Worldviews, Knowledges, and Research: The Development of an Indigenous Research Paradigm. *Journal of Indigenous Voices in Social Work.* 1. (1). http://www.haawaii.edu/sswork/jivsw. E-ISSN2151-349X. pp. 1-16.

Hart, Michael Anthony. (2012). The Mino-Pimatisiwin approach and Sustainable well-being: From Inward Journeys to Social Justice. University of Manitoba. 1-42.

Hill, Dawn Martin (2011). Traditional Medicine and Restoration of Wellness Strategies. EVA BC NVCAW/Spring.

Juneau, Lucy. (2019). NWAC meets with Prime Minister's office. https://www.mwac.ca

Johnson, Rebecca, Napoleon, Val. (2016). *Gender Inside Indigenous Law Toolkit.* Indigenous Law Research Unit, University of Victoria.

Kalichman, S. C., Pellowski. J., Kalichman. M. O., Cherry. C., Detorio. M., Calvin. M., and Schinazi, R. F. (2011). Food insufficiency and medication people living with HIV/AIDS in urban peri-urban setting. *Prevention Science.* 12 (3).324-332.

Kovach, Margaret. (2009). *Indigenous Methodologies Characteristics, Conversations, and Contexts.* University of Toronto Press. Toronto Buffalo London.

Lee, Mary, (2006). *Cree (nehiyawayak) Teaching*.FourDirectionTeachings.com. Aboriginal. Online Teachings and Resource Centre. Retrieved from http://www.fourdirectionsteachings.com/transcripts/cree.html

Malone, Kelly G. (2018). Indigenous children in care to stay within their communities. *The Canadian Press.* Winnipeg. March 19.

Mawhiney, A. M., Nabigon, H. (1996). *Social Work Treatment: Interlocking Theoretical Approaches.* 6th Edition. Oxford University Press.

McCall, J., Browne. A. J., Reimer-Kirkham. S. (2009). Struggling to survive: The difficult reality of Aboriginal women living with HIV/AIDS. *Qualitative Health Research*, Dec. 19. (12). 1769-1782. doi:10.1177/1049732309353907 [doi]

McCall, J., Lauridsen-Hoegh, P. (2014). Trauma and cultural safety: Care to HIV-infected women of Aboriginal descent. *Journal of the Association of Nurses in AIDS Care 25,* (Supp.) S70-S78

McGregor, Deborah. *(2012). Traditional Knowledge: considerations for Protecting Water in* Ontario. *The International Indigenous Policy Journal.* Volume 3. Issue 3. Water and Indigenous People. Article 11.

McGregor, Deborah. (2018). From 'Decolonized' to Reconciliation Research in Canada: drawing from Indigenous research Paradigms. *ACME an International Journal for Critical Geographies.* 17(3): 810-831.

Mekkonen. J., Raphael, D. (2010). The Social Determinants of Health. The Canadian Facts. Canadian Mental Health Association. https://ontario.cmha.ca/provincial-policy/social-determinants/

Michill, H. (2015). Bush Cree Storytelling Methodology: Northern Stories That Teach, Heal and Transform. *In Education. Exploring our educational landscape.* 2. 2.

Mignone, J., Migliardi. P., Harvey. C., Davis J., Madariaga-Vignudo. L., Pindera. C. (2015). HIV as chronic illness: Caregiving and social population. *Journal of the Association of Nurses in AIDS Care*,26 (3), 235-245.

Nabigon, H. & Mawhiney, A. M. (1996). Aboriginal theory. A Cree Medicine Wheel guide of healing. Social work treatment. 4TH edition. F. J. Turner. Toronto. The Free Press interlocking theoretical Approaches: 18:38.

Native Women's Association of Canada. (2010). Fact sheet; Missing and Murdered Aboriginal Women and Girls in Manitoba. p.1-2.

Nettleton, C., Napolitano A., Stephen Current Knowledge of the Social Determinants of Indigenous Health. Working Paper. Technical Report. LSHTM.http://researcheronline.lshtm.ac.uk/6662/

Ningewance, P. 1969. *Ininimotan: Becoming a Successful Cree Eavesdropper*. Mikisiw-Asiniy

Noor, K. (2008). Case Study: A Strategic Research Methodology. *American Journal of Applied* Printing.

Nine Circles Community Health Center. Retrieved from: ninecircles.ca/

Okimasis, J., Wolvengrey. A. (2008). *How to Spell in Cree: The Standard Roman Orthography*. Horghton Boston, misaskwatominihk (Saskatoon).

Pontisso, R., (Ed.) (2011). Collins Canadian English Dictionary & Thesaurus. Toronto. Harper Collins Publishers.

Piourde, Pierre. (2018). *HIV infections on the rise among Manitoba women, First Nations.* https://www.cbc.ca/news/canada/manitoba/hiv-infections-on-the-rise-among-Manitoba-women-first-nations-1.754558.

Public Health Agency, *Annual Statistical Update. HIV and AIDS.* 2014. http://www.gov.mb.ca/health/publichealth/surveillance/hivaids/index.html.

... *Annual Statistical Update HIV and AIDS 2016.* http://www.gov.mb.ca/health/publichealth/surveillance/hivaids/index.html

Rent 4 U. www.kijiji.ca/

Returning to Spirit (2008). info@returningtospirit.org

Royal Commission on Aboriginal People. (1995). Choosing Life, Special Report on Suicide among Aboriginal People. (Ottawa. Supply and Services. P.24.

Scroggie, A. M. (2009). Preserving tradition and enhancing learning through youth storytelling. *Journal of Bhutan Studies*. 20, 76-92.

Simpson, Leanne. (2011). *Dancing on Our Turtle's Back*: Stories of Anishinaabe Re-creation, Resurgence, and a New Emergence. ARP Books. Winnipeg.

Social Assistance for Single Person. http://www.gov.mb.ca/

Smith, Tuhiwal L. (1999) *Decolonizing Methodologies Research and Indigenous Peoples.* London, New York. University of Otago Press.

StatsCan. Info stats. STATCAN@canada.ca

Struthers, Roxanne. PhD., PHN., RN., H.N.C., C.T.N. (2000). The Lived Experience of Ojibwa and Cree Women Healers. *Journal of Holistic Nursing,* Vol. 18. No. 3, September. 2000. 261-279.

Tough, Frank. (1990) Go Pitch His Camp: Native Settlement Patterns and Indian Agriculture. Lost Harvest. *Prairie Indian Farmers and Government Policy.* Montreal. McGill-Queens' University Press. 15-4

Truth and Reconciliation Commission of Canada: Calls to Action-TRC (2015). www.trc.ca/websites/trcinstitution/File/2015/Findings/Calls_to_Action_English2pdf

Valaskakis, Gail. Dion Stout, Madeline and Guimond. Editors. *Restoring the Balance*: *First Nations Women, Community, and Culture*. University of Manitoba Press.

VandenBos, *Gary R., (Ed.) (2012). Publication Manual of the American Psychological Association*. Sixth Edition. American Psychological Association. Washington D.C.

Weiser, S. D., Frongill. E. A., Ragland. K., Hogg. R. S., Riley. E. D., & Bangsber. D. R. (2009). Food insecurity is suppression among homeless and marginally housed HIV-infected *of General Internal Medicine*, 24 (1), 14-20.

Wenger-Nabigon, Annie. (2010). Promising practices in Mental Health: Emerging Paradigms for Aboriginal Social Work Practices. *The Native Social Work Journal.* Volume 7. Laurentian University Press.

Wenger-Nabigon. Anne. (20.) The Cree Medicine Wheel as an Organizing Paradigm of 139-161. Laurentian University Press

Willows, Noreen D. (2005). Determinants of Healthy Eating in Aboriginal People in Canada. The Current State of Knowledge and Research Gaps. *Canadian Journal of Public Health.* Volume 96,3.

Wilson, S. (2001). What is an Indigenous Research Methodology*? Canadian Journal of Native Education.* 25, 2.

Wilson, S. (2008). *Research is Ceremony. Indigenous Research Methods.* Halifax and Winnipeg. Fernwood Publishing.

Young, D., Rogers, Robert., & Willier, R. (2015). A Cree healer and his Medicine bundle. Revelations of Indigenous Wisdom. Berkeley, California. North Atlantic Books.

Zak, Paul J. (2015). Why Inspiring Stories Make Us React: The Neuroscience of Narratives. *Cerebrum.* .2, 1.

Appendices

Appendix A

Description of Study

Title: Promoting Minopimatisiwin: Urban Aboriginal with HIV.

Researcher: Lorraine Cameron-Munro

Background of study: Although there is epidemiology research on HIV, there is a lack of research on the lived experiences and the perspectives of urban Aboriginal women living with HIV. This lack of research is the reason for this research study, in obtaining an accurate account of urban Aboriginal women well-being.

Research: The purpose of this proposed research is to explore the lived experiences of urban Aboriginal women who live with HIV, and to explore the challenges they face living with the effects of HIV. I will collect data by listening to the voices of the urban Aboriginal women and hopefully obtain a better understanding of their health and well-being.

Participants: I will interview 6 -10 women. Criteria for participation: HIV positive, live in Winnipeg, over the age of eighteen and self identify as Aboriginal or native, status or non-status, Metis, Inuit.

Study Design: I will have sharing sessions where the participants can share their experiences. If uncomfortable with this method, I can arrange for individual interviews. I will have a talking circle with the participants to listen to any suggestions or recommendations for culturally sensitive HIV prevention strategies. During the sharing sessions, I will have open-ended questions guiding the study.

Questions: How did you learn of your HIV status? 2. Can you describe your experience living with HIV and how it has affected your life? 3. How do you cope living with HIV? 4. Can you share how your life was at time of diagnosis of HIV and present day? 5. What suggestions do you have, if any, a more culturally specific HIV prevention

Appendix B

Background Demographics

All information on this sheet will be kept confidential. This sheet will be kept in a locked drawer.

Date.....
Birth Year.....

Do you identify as Aboriginal?.....

If yes, are you First Nations status.....First Nations non-status.....Metis.....Inuit.....

When were you diagnosed HIV?.....
Did you or your parents go to Indian residential school?.....

How long after you knew you had HIV; did you seek medical care for HIV.....

Do you receive medical care for HIV?.....

HIV medications……

If yes, why did you stop taking HIV medications at any time?.....

Other information you would like to share that is not covered in this sheet

.....

…….

In your experience, what do you consider the most important service/s you would like to see available to you.....

.....

Appendix C

Questionnaire Guide

1. I am interested in hearing your experience living with HIV. Can you share about your experience living with HIV?

Probes: Can you share the feelings or emotions you experienced when you first heard your diagnosis of HIV?

Can you share with me when you disclosed your diagnosis and with who?

2. I am interested in learning what challenges you face, as an Aboriginal woman living with HIV

Probes: Can you share with me about the support you have from your Immediate. family, extended family, friends and your Aboriginal community?

Can you share with me who you can talk to about your illness?

3. I am hoping to get suggestions what would improve culturally specific HIV prevention strategies. Can you share any ideas you may have?

Probes: Is there anything you would like to see for Aboriginal communities who experience with HIV?

How important is having Aboriginal front line service providers for support and services to you?

Appendix D

Participants Informed Consent Form

Providing Minopimatisiwin: Urban Aboriginal Women with HIV

You are invited to participate in this study because you are an Aboriginal woman who has been affected by HIV.

Purpose of Study: The purpose of this study is to explore the lived experiences and challenges of living with HIV from the perspectives of Aboriginal women. This research will contribute useful information documenting your life experience that Aboriginal women face when affected by HIV.

Requirements: Participants are invited to voluntarily fill out a background information and participate in three storytelling circles to share your life experiences living with HIV. The circle length is flexible, but it is estimated will last approximately two to three hours. It will be audio taped to ensure accurate representation of your words. You will be required at later time to review the written transcript to verify the accuracy of your story and research findings.

Participants: The study requires voluntary participation of Aboriginal women who have experienced living with HIV.

Potential Benefits: There are no potential benefits to the participants other than sharing your experience of living with HIV, along with gaining knowledge which you may acquire about the research process.

Potential Risk: Participants should not experience any discomfort or risk in completing the background information or participating in the storytelling circles. If any of the participants experience distress due to the content of the topic, An Elder will be available for emotional support. If there is a crisis, I will stop the circle and call crisis management personnel for consultation.

Confidentiality of the Data: Your name and any other identifying information will not be associated with your data. Your consent form will be stored separately from your data. My supervisor and I will have access to individual results of the study, only a summary of results. The data and results will be kept in locked drawer in my faculty advisor's office at University of Winnipeg.

As the researcher, I am requesting that during the storytelling sessions that confidentially be kept by all participants, however I have no control this matter.

If a participant wishes to be identified in the research study, please indicate here:
Yes…… No……

Withdrawal from study: Participation is voluntarily, if at any time you during the research process, you decide for any reason you do not wish to participate you are free to withdraw from the study. Your decision to not participate will not affect your relationship with University of Winnipeg or Nine Circles Community Health Center.

Questions: If you have any questions at any time, prior to your decision to participate in the study, or during and after a storytelling circle, please feel free to contact t at 204-390-7119

This study will be submitted to the Research Ethics Board, University of Winnipeg. If participants have any questions or concerns about their rights or treatment, they can contact the

Chair of the Research Ethics Board at 204-786-9058 or by email at ethics@uwinnipeg.ca

YOUR PARTICIPATION IS VOLUNTARY. YOUR SIGNATURE INDICATES THAT YOU DECIDED TO PARTICIPANT IN THIS STUDY. AFTER READING THE INFORMATION PROVIDED, YOU WILL BE GIVEN A COPY OF THIS INFORMED CONSENT FOR YOUR RECORDS.THE RESEACHER WILL ALSO KEEP A SIGNED COPY ON FILE.

PARTICPANT'S SIGNATURE……. DATE…….

RESEARCHER'S SIGNATURE……. DATE…….

Researcher: Lorraine Cameron-Munro, University of Winnipeg, Indigenous Governance 204-390-7119

Research supervisor: Dr. J. Pelletier, Associate Professor Graduate Studies, Department of Indigenous Studies, University of Winnipeg.

Appendix E

Elder's Informed Participation Consent Form

I have read and understand the information about a research study being conducted by Lorraine Cameron-Munro, graduate student in Indigence Governance at University of Winnipeg, under the supervision of Dr. J. Pelletier, Assoc. Professor, Department of Indigenous Studies at University of Winnipeg.

I understand that this project has been approved by the UW Research Ethics Board of the University of Winnipeg. I have been offered an opportunity to ask questions regarding the project. If further questions arise, I may contact Lorraine Cameron-Munro at lcmunro5@gmail.com. or at 204-390-7119 or Lorraine's supervisor Dr. J. Pelletier at j.pelletier@uwinnipeg.ca.

If I still have questions or concerns with the study, I may contact the Program Officer, Research office at University of Winnipeg at 204-7869056.

…….

Circle appropriate word below:

I do / do not agree to participate in the study as an Elder for emotional support for research participants.

Fill in blank spaces with your information

Name (print)……...

Email address……. work phone……

Signature……Date…….

Principal Investigator……. Date……