Braiding a Rug of Understanding: Oral Health Perspectives of a Métis Women's Kinship Group in Northeastern Alberta

by

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Abstract

Background: There are notable gaps in health research that do not reflect the population demographics and diversity of Indigenous Peoples in Canada. Métis people make up one-third of the Indigenous population in Canada, yet their experiences of health go underrepresented within a wider field of pan Indigenous health research. The paucity of Métis research spans across many health disciplines, including oral health, and may hamper individual and collective self-determination and the work of Métis governance to advocate for the oral health and well-being of citizens.

Purpose: The purpose of this study was to privilege the voices of Métis women, as traditional caregivers and keepers of health and wellbeing in their communities, to co-create a deeper understanding of the oral health experiences and perceptions of a Métis women's kinship group in northeastern Alberta.

Methods: A Métis kinship visiting research methodology known as *Keeoukaywin* was adopted for use in this study. This project recentred the ways of being, knowing and doing of Métis Grandmothers and Aunties. The researcher visited with ten women (knowledge holders) within her kinship network around their experiences of oral health and oral healthcare services for themselves and their families. Two individual visiting sessions with each knowledge holder and one group gathering was held. Consent was obtained for all visiting sessions which were audio recorded and transcribed. Collaborative story analysis was completed through a culturally relevant framework of Métis rug braiding. Research questions guided the collection of their stories as well as the organization and building of the strands of their collective stories. The women's stories about oral health experiences were intertwined into four main braids

synthesizing and sewing together the collaborative meaning of their experiential knowledge into a braided rug of understanding.

Results: The four braids represented the kinship group's attitudes and beliefs about oral health, self-identified barriers to oral health, facilitators to their oral health, and their vision for oral health and oral healthcare delivery for Métis people. These knowledge holders held holistic beliefs and pragmatic and adaptive attitudes towards oral health. They identified geographical, food, water, and financial resource limitations as well as racism and community disconnection as barriers to oral health. Facilitators to oral health included knowledge transmission facilitated by Métis women's kinship systems and ways of being. The women in this kinship group remembered and recognized the integration of public health promotion in community schools from the 1970s through the 1980s as embedded into these same knowledge systems. Reflecting on factors influencing their oral healthcare seeking behaviors and their experiences of oral healthcare services, the knowledge holders visioned futurisms of resilience fostered through women's cultural supports and culturally safe, decolonial oral healthcare systems and spaces with relational oral healthcare provision.

Conclusion: This study provides a descriptive understanding of attitudes and beliefs Métis women hold towards oral health for themselves and their families. Further insight was gathered about barriers and enablers Métis women have experienced in relationship to oral health services. Findings from this thesis demonstrate individual and collective beliefs of holistic oral health as connected to overall health, as well as pragmatic and adaptive attitudes to attend to the oral health needs of themselves and their families in the face of socio-economic, systemic, and structural barriers to care. The study is limited to one Métis women's kinship group and may not speak for all Métis women. However, the stories that were gathered with this Métis women's

kinship group does resonate with emerging Métis specific, community-led health literature. The findings attended to individual and cultural promotive factors facilitating oral health such as women's cultural wellness and visioning for relational, culturally safe service provision.

Preface

The research project, of which this thesis is a part, received research ethics approval from the University of Alberta Research Ethics Board, Project Name “Hidden Smiles: Métis Women’s Oral Health Experiences in Alberta”, Pro00121986, August 2022 – August 2024.

Dedication

This work is dedicated to my mother, my first teacher and mentor, Annette Rondeau. Her deep faith in God and love for her family is braided into my very being.

Acknowledgements

This work would not have been possible without the tremendous support of many people I am blessed to call family, friends, kin, and colleagues. Firstly, I would like to thank the women in my family and the New Dawn Métis Women Society in the St. Paul/Cold Lake District 12 of the Métis Nation in Alberta who agreed to be the soul of this research. Opening their homes and their hearts to me made this project possible. Their companionship, prayers, encouragement, knowledge, and support along this journey was indispensable.

I am grateful for the financial support of the University of Alberta Situated Knowledges: Indigenous Peoples and Place (SKIPP) grant that provided the funding for this study. I also want to acknowledge the Indigenous Primary Health Care and Policy Research Network in Alberta (IPHCPR) for their support throughout the course of my graduate program. The graduate student stipend, writing retreats and networking opportunities all fostered connection and community that will last beyond this program.

A heartfelt thank you to Dr. Sharon Compton who was not only my graduate student supervisor but also has been a valued mentor since I first became a dental hygienist in 1994. Dr. Compton's passion for and dedication to dental hygiene has always inspired and encouraged me to expand my professional knowledge and practice. I appreciated her knowing way that kept me gently focused and on task whenever my thoughts and plans got bigger than my reality.

I also want to thank Dr. Minn Yoon who generously accepted to be my co-supervisor. Her gracious candor and authentic curiosity broadened my thinking and challenged me to fully embrace what I knew, what I forgot and what I did not yet know all as opportunities to develop and grow in my identity as a researcher and academic.

I will be ever thankful for Dr. Cindy Gaudet's wise counsel and encouragement as my committee member and friend. She is a gifted teacher and mentor who creates community and belonging wherever she goes. Visiting, loving, and researching is as natural to her as breathing and she generously breathed her life into me over and over whenever I was almost spent.

Finally, none of this work would have been possible without the unwavering support of my family and friends. My parents have been praying for me every day since before I was born, and in these last few years, I know their prayers have moved mountains for and sustained me through the hardest times I have ever known. Thank you to my sister and brothers for being there for Mom and Dad when I could not, and for being so willing to pick up the balls I kept dropping along the way. I cannot thank my children, Jessey, Jade, Garrett, Brynna, Aaron, Caleb, and grandson Lachlan enough for walking this path with me. I could not have done it without their patience and understanding. When I would lose sight of home or the day-to-day tasks of life, they all pitched in to keep us afloat and to keep me sane. Most importantly, I want to thank my husband Curtis for his belief in me and his faith in God. He has sacrificed and worked so hard to provide for and love me in all that I have felt called to. I am forever grateful to him.

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CHAPTER 1: INTRODUCTION

In this first chapter, I will introduce and situate myself as this is directly tied to my research questions and journey. Alongside the questions, I will provide historical, social, political, and academic context to the aim and purposes of my research inquiry. In this section, I will provide a road map for the readers to support an understanding of the expectations and the meaning making process of my research.

1.1 Locating Myself in The Journey

The ethos of Indigenous research methodology calls for researcher self-location, a critical reflection on who they are, where they are from and to whom they are accountable. In so doing, researchers anchor their purpose, plans, and priorities in an enduring commitment to all the relationships the research will build (Absolon, 2022).

I live on Treaty 6 land, the traditional territory of the Cree and Dene people and homeland of the Métis. I call Cold Lake Alberta home. My mother is from St. Paul de Métis and my father is a French-born settler from Bonnyville, Alberta. I am proud to walk the spectrum of both these worlds and celebrate the strength and resilience this heritage has instilled in me. I am on my 54th trip around the sun and started this graduate program in January 2021. I am a wife and mother of six, grandmother to one, and auntie to many. I feel blessed to have the opportunity to walk this research journey that will soon earn me a master's degree in a field of healthcare, dental hygiene, that I have dedicated my professional life to for 30 years. This is not my accomplishment alone, it belongs to my mentors, my community, my family, my husband, my children, and all my relations. I know that I have been supported and encouraged by the strong matriarchs and grandfathers who came before me, by the many beautiful folks in my kinship network and those I have the honor of calling friends. After more than 15 years as a clinician

working in a traditional dental practice, I started and have maintained my independent dental hygiene clinic since 2011. This practice is dedicated to improving access to care for those experiencing barriers to traditional oral healthcare delivery. With a mobile clinic, I bring full scope of dental hygiene practice to Indigenous communities, long term care residents and homebound individuals in the Lakeland area of northeastern Alberta. My storefront clinic in Cold Lake provides affordable, accessible, inclusive, and equitable care to all.

Community through an Indigenous lens encompasses not only present-day relationships but also ancestral relations, physical environment, and land. Consideration of all these intersecting relationships for both the researcher and the communities with whom knowledge is sought and created can be complex reflexive work and is key to ensuring due rigor and integrity. Working from an Indigenous research paradigm, according to Wilson, involves recognizing that neither the relationships we have nor the relationships we create in the research process can be compartmentalized from our existence (Wilson, 2008). Community is integral to all research.

In her article on witnessing, Hunt emphasizes the importance of interrogating the impact a researcher's own multiple situated identities have on their research process (Hunt, 2018). Community affiliations can impact a person's values, attitudes, interests, and goals. I would add, some communities may be more influential than others and dependent on an individual's worldview. For myself, my primary community is my family, both immediate and extended. I am also part of the Métis communities of both the Métis Nation in Alberta and the faith community on Elizabeth Métis settlement where we have attended Roman Catholic services. I am part of the provincial New Dawn Métis Women Society and organize events for Métis families in my district. Professionally, I belong to the community of dental hygienists in Alberta and Canada and to another community of independent dental hygienists. Here at the University

of Alberta, I am a graduate student and a part-time dental hygiene clinical instructor. All these affiliations contribute differently to my identity and impact my day-to-day choices to varying degrees.

One consideration that drew me to work in a service field like oral healthcare is a desire to contribute to people's well-being. In part, I attribute this to my Christian upbringing and our strong Métis family values of caring and looking out for one other. While I am indeed drawn to contributing to change and advocating for the universally underserved, deep within I feel compelled to address colonization in the healthcare system and do good work for my relations, my communities, and Indigenous peoples. As Wilson points out in his chapter on relationality, we are the relationships we hold or are a part of; the core of our identity is tied to these connections (2008).

Answering and living my personal and professional life congruent to my relational responsibilities as I experience them is integral to my personal sense of wellbeing. Honoring all my relationships is formative to becoming a strong, healthy individual and researcher (Wilson, 2008). Tallbear points out that staying in relation, standing with the people in community-engaged research in Indigenous communities is not a simple, onetime formulaic giving back (2016). For me, how I see community and relationships translates to research that is cooperative and co-creative. These deep reciprocal and unending connections are historical and current and my obligations to them are as enduring as the Métis infinity symbol of our Nation's flag.

I have always loved the way we, as Métis people, visit. My parents took us on visits, and they welcomed visitors who came to work, play, or pray. It always involved great food and laughter. The ethic of care inherent in a good visit was mutual and sincere whether you were the

host or the visitor. As a dental hygienist, this same ethic carries over. Every appointment for me is a chance to visit and informs the work I now pursue as a graduate student. As a healthcare provider, I have shared in many of the stories and experiences of Métis friends, family, and community and while the Métis experience of oral health is as diverse as the people themselves, universally true to who we are, our stories are laden with smiles and laughter.

1.2 Background

Indigenous Health Research

Historically, research has earned a pernicious reputation among Indigenous peoples; many Indigenous communities remain wary of researcher misinterpretation, misrepresentation, misuse, and misappropriation of Indigenous knowledges and experiences (Absolon and Willett, 2004; Smith, 2012; Wilson, 2008). Exploitive, extractive, and harmful research done on and to Indigenous Peoples has contributed to what has been described as a global sentiment among Indigenous communities of being "researched to death" (Hayward et al, 2021; Smith, 1999).

The Canadian Institute of Health Research (CIHR) was established in 2000 as Canada's funding investment agency

> "supporting knowledge creation and knowledge translation intended to inform and drive health policies, programs, practices, products and services to ensure optimal and equitable health outcomes for all Canadians" (CIHR, n.d-c).

Responsive to contentious and unethical Indigenous research practice, CIHR 2007-2010 guidelines and more specifically, the 2009 Tri-Council Chapter 9 policy statement *Research involving the First Nation, Inuit, and Metis Peoples of Canada*, was developed to provide a framework intended to ensure culturally appropriate and ethical research with Indigenous people in Canada.

Notwithstanding these guidelines, it has been asserted that Indigenous research that is not community driven, culturally responsive and lacking in epistemological critical reflexivity is in danger of power imbalances between communities and researchers/institutions, resulting in little meaningful community collaboration or benefit at best and continued propagation of cultural and political neo-colonial domination at worst. (Brugh 2013; Hayward et al, 2021; Rigney, 2001; Smith, 1999). Across disciplines, collaborative, community engaged inquiry processes reconceptualize Indigenous research happening with rather than to Indigenous people (Gaudry, 2018). A concomitant outpouring of Indigenous scholarship legitimizing, privileging and recentring traditional and contemporary Indigenous knowledge in the academy is furthering decolonization and self-determination in research (Sommerville and Turner, 2020 and McIvor 2010). Research grounded in culture-specific traditions, customs, and community priorities informs relevant and equitable development of self-determined health promotion policy and programming.

Indigenous health research has also been criticized for deficit-based approaches, analyzing disparate health outcomes that pathologize populations experiencing health inequalities (Hayward et al, 2021; Hyatt et al 2019; Nelson and Wilson, 2017). Repeated examination of Indigenous health deficits lacking the historical and social context of colonization and intergenerational trauma stigmatizes health issues as being inherently cultural, increases negative stereotypes and risks the cultural safety of Indigenous people seeking healthcare services (Hyatt et al, 2019). The common pattern of Indigenous health research approached through outside observation and analysis with limited local input or perspective contributes to authoritative, hierarchical policy and programming that fails to generate meaningful change and disempowers the people and communities it intends to help (Simonds and Christopher, 2013).

Promisingly, the CIHR has continued to keep pace with these assertions and the heightened awareness of the power and promise research holds to propagate or belie decolonization. The 2014/15 - 2018/19 CIHR Strategic Plan resulted in the *Action Plan: Building a healthier future for First Nations, Inuit and Métis Peoples* (the Action Plan) in 2016. The Action Plan accepted the Institute of Indigenous Peoples Health's (IIPH) definition of Indigenous Health Research (IHR) as

> "any field or discipline related to health and/or wellness that is conducted by, grounded in, or engaged with, First Nations, Inuit or Métis communities, societies or individuals and their wisdom, cultures, experiences or knowledge systems, as expressed in their dynamic forms, past and present" (CIHR, n.d-b).

This definition remains congruent today, with the CIHR Strategic Plan (2021-2031) *Priority C: Accelerate the Self Determination of Indigenous Peoples in Health Research* and *Priority A: Advance Research Excellence in All its Diversity* promoting and furthering an inclusive concept of research excellence that embraces

> "multiple ways of knowing and non-traditional research methodologies and outputs as cornerstones of Canadian research. It will also recognize patients, the public, providers, decision makers and other users of research outputs as active collaborators throughout the entire research process" (CIHR, n.d-a).

It is on these shifting and rising tides of decolonial research inquiry in Canada that this thesis finds itself propelled through the breaking waters of change far more easily than originally experienced by first wave Indigenous scholars like Marlene Brant Castellano, Joseph Couture, Leroy LittleBear, and Verna J. Kirkness in the late 80s and 90s with momentum built by second

and third wave Indigenous academics like Jo-anne Archibald, Margaret Kovach and Shawn Wilson (Archibald et al, 2008; Pidgeon et al, 2013).

Indigenous Peoples in Canada include distinct subpopulations whose cultural, political, and linguistic histories and contemporary experiences demonstrate significant variability in health needs dependent on local contexts (Smylie and Firestone, 2015). The reemergence and reclamation of diverse, culturally specific, theoretical, and methodological approaches to health research engages Indigenous people in relevant community-based work that has been transformative and emancipatory (Kovach, 2005; Archibald et al, 2006). Future Indigenous health research in Canada, developed according to the CIHR's acknowledgement of these diverse wisdoms, cultures, and knowledge systems of diverse Indigenous Peoples in Canada, should include critical appraisal of inclusivity and representation.

Métis Health Research

Health research, at the dawn of the 21st century, did not reflect the population and geographic diversity of the Indigenous population with urban First Nation, Indigenous seniors and Métis being disproportionately underrepresented (Wilson and Young, 2008; Young, 2003). Even though Métis peoples comprise over one-third of the total Indigenous population in Canada, they remain underrepresented as a distinct category in most health statistics and health research (Evans, et al., 2012; Gmitroski et al, 2023; Lavallee et al., 2016). A recently published scoping review of Métis health research demonstrated that while Métis specific health research was trending, nearly half of the examined works lacked elements of community engagement and were based on survey data extraction (Gmitroski et al, 2023). This gap in research spans across health disciplines among which oral health would be implicated (Kumar, Weshe, and McGuire, 2012; Lee, et al., 2022; MacDougall B., 2017).

Métis Oral Health Research

Oral health research in Canada has also been predominantly pan-Indigenous, or First Nation/Inuit community-focused and dependent on large scale surveys lacking local community engagement. Research relying on national health surveys like the oral health component of the Canadian Health Measures Survey (CHMS) and the Canadian Community Health Survey (CCHS) do not separate Métis specific data from aggregated Indigenous data. The federal Aboriginal Peoples Survey (APS), a disaggregated data set, focuses on social and economic measures and provides limited health information that does not include oral health (Statistics Canada, 2011). Further to the dedicated oral health self-reported questionnaires and clinical assessments of the CHMS in 2007/09 and summaries of the aggregated data for Indigenous peoples and the public, Canada also funded the First Nation Oral Health Survey (FNOHS 2009/10) and the Inuit Oral Health Survey (IOHS 2008/09). No such 'Métis Oral Health Survey' exists.

The persistent gap of available research on the oral health of Métis people in Canada contributes to the concomitant link between the lack of understanding Métis historical and contemporary colonial, socioeconomic, and political contexts and Métis health outcomes that produce further barriers to facilitating evidence-based advocacy, funding, policy, programming and clinical health service delivery for Métis people (Gmitroski et al, 2023; Hyatt et al, 2019; Lee et al, 2020; MacDougall, 2017).

1.3 Research Goals and Questions

The purpose of this research was to contribute to understanding the perceptions and oral health experiences of a kinship group of Métis women living in northeastern Alberta, Canada.

Centring Métis ways of being, knowing and doing as embodied in the enactment of kinship and relationality, the perspectives of Métis people were gathered through generations of Métis female knowledge holders, matriarchs who hold central roles in the health and well-being of their families and communities (Monchalin, Smylie, Bourgeois, and Firestone, 2019).

The central research question was: How do Métis Albertans perceive their oral health experiences? Research sub-questions included:

- What beliefs and attitudes towards oral health do Métis people hold?
- What are the self-perceived oral health treatment needs of Métis people?
- What experiences do Métis people have in seeking oral healthcare services in Alberta?
- What factors influence Métis people accessing oral healthcare?

1.4 Thesis Overview

I start this thesis in the second chapter sharing knowledge of the historical, cultural, social, and political identity of Métis people broadly in relation to the complexity of settler-colonialism as a critical contextual lens through which to understand Métis health and well-being. Demonstrating first how the literature points to needed Métis-led research and why distinction-based research matters broadly, I narrow this down to what is known about Métis health and oral health. I share the literature that has helped shape my journey as a Michif oral health researcher and make correlations to the significance and importance of kinship that will inform a braided understanding of Métis oral health experiences using existing theories of intersectionality, Indigenous feminist theory, Indigenous resilience, and relationality. These theories subsequently frame the design, methodology, interpretation, and presentation of the knowledge generated by this thesis.

In chapter 3, I amplify Indigenous Research Methodology (IRM) and the learnings from Indigenous scholars. As part of this process, I unfold its significance to my respective research and signal to the ways in which kinship, methodology, theory, and methods are interrelated. I point to the literature that uplifts IRM and I demonstrate the ways in which my research contributes to the threads of resistance, kinship love and co-creative meaning making that is an emergent, living praxis. I point to a conceptual model of *keeoukaywin* from my kinship perspective and community experience as it unfolded in this research praxis.

In chapter 4, I introduce more specifically the knowledge makers and holders who are co-creators in my research and demonstrate the ways in which Métis women's relationality is the heart of my research. I will introduce the significance of rug braiding as an emerging framework in a collaborative story process of meaning making. Its intricate link to keeoukaywin and Métis women's kinship praxis is demonstrated.

Chapter 5 is the heart of this thesis. It lifts the passionate voices of our matriarchs to assert the power and promise of Métis self-determination in knowledge generation and translation. Here, I unfold the ways in which a braided rug weaves together the stories, wisdom, and experiences of Métis women whose voices are re-centred to understand the oral health experiences, perceptions and needs of Métis families and communities. I demonstrate the ways we collectively re-imagined beyond erasure, assimilation, systemic barriers, and racism to assure our sovereignty and respond collectively to the inequities of Métis oral health from a position of strength.

Chapter 6 offers a concluding overview of the findings grounded in what is currently known in the literature focusing particularly on current work in Métis relevant contexts.

Chapter 7 picks up from the previous chapter's overview and leads into a broader reflection that recognizes how this graduate research project initiates a yet to be explored discussion of Métis sovereignty in community led research collaborations through Indigenous research methodology. The chapter then concludes the thesis, offering reflections on my journey as an Indigenous graduate student, navigating the responsibilities of research done in a good way.

CHAPTER 2: GIVING CONTEXT TO INDIGENOUS ORAL HEALTH LITERATURE AND THE METIS

2.1 The Metis and the Road Allowances of Research

Who Are the Metis?

The 2021 Census reported there were 1,807,250 Indigenous people in Canada, of which 34.5% self-identified as Metis (Statistics Canada, 2022). The Metis are a post contact Indigenous people recognized under Section 35 of the Constitution and have been a part of Canada's landscape since before Confederation (Lamouche, 2002). Contrary to a misconceived notion that would have Metis identity defined by a mixed blood quantum of First Nation mothers and voyageur, settler fathers, this racialization alone does not explain the genesis of an Indigenous people (Chartrand, 2007). In Cree, they have been called "Otipemisiwak," meaning "the people who own themselves" (University of Alberta, n.d.). The Métis are a distinct Indigenous people with unique and collective historical, political, cultural, and economic structures, born in the fur trade era of the late 1700s, growing and rising into a Nation in the context of the growing buffalo economy of the nineteenth century (Andersen, 2014; Chartrand, 2007; Teillet, 2021). Forming communities along these trade networks, the ethnogenesis of the Métis people was nurtured and sustained through extensive kinship networks that supported their united political and economic solidarity against the monopoly of the Hudson Bay Company and the eventual usurping of their sovereign rights by the Dominion of Canada (Macdougall, 2017; Weinstein, 2007). In 1870, regarding the Red River Métis, Prime Minister MacDonald wrote that they were problematic and needed to be

> "kept down by a strong hand until they are swamped by an influx of settlers" (Sprague, 1980:74).

The Métis experienced growing racial tensions and discrimination from the growing settler society and forced land dispossession. While some chose to remain in Red River, some chose to relocate along the South Saskatchewan River (Payment, 2009; Teillet, 2021). The 1885 Resistance was another attempt for Metis people to stand and to defend their sovereignty, rights to land and to live freely (Payment, 2009; Teillet, 2021). They were repeatedly forced or swindled out of their land, homes, and communities through crooked land script schemes as new colonists moved further and further west (Teillet, 2021). Some Métis family kinship communities came to be known as the *road allowance people*, settling on crown lands set aside for road construction (Orth, 2002). The Métis endured repetitive cycles of dispersal and relocation; a colonial legacy of erasure, assimilation, segregation, and marginalization that has ongoing impacts to this day (Fiola, 2021).

> "By the early 20th century, the Metis were landless and dispersed, and families struggled to remain together and nurture the social supports that had kept them healthy for generations" (Macdougall, 2017).

Understanding Métis history within Canada's colonial reality is integral to appreciating the social determinants of health Métis people experience (MacDougall, 2017). Equally integral to this contextualization is the recognition that gender discrimination, embedded in historical and contemporary colonial ideologies and systems, has had and continues to have deleterious effect on the roles of Métis women as the 'foundations of resistance' doing the deep work of guarding and maintaining kinship ties and community health and wellness (Anderson, 2016).

Les Femmes Michif (Women of the Métis Nation)

Identity and culture are strongly connected to Indigenous health and well-being (Auger, 2016). Métis kinship networks are at the heart of Métis identity and survival, principled through matrilineal Cree laws of *wahkotowin* that direct respectful relationship to all things human and of creation; laws traditionally shared across the generations by women (MacDougall, 2006; MacDougall, 2010; Monchalin, Smylie, Bourgeois, and Firestone, 2019). Métis culture, medicine, wellness practices and ways of knowing are passed down from grandmothers and aunties through social relationships (Flaminio, Gaudet, and Dorion, 2020; Hodgson-Smith and Kermoal, 2016; Kermoal, 2016). Métis women of the 19th century were the traditional midwives, herbalists and proverbial doctors and pharmacists of community and continue to share knowledge that is central to the health and wellbeing of community today (Monchalin, Smylie, Bourgeois, and Firestone, 2019; Anderson, 2011). For many Métis women, health is collective and linked to the health of their families and community (Kermoal, 2016; Monchalin and Monchalin, 2018). As such, researchers and policymakers seeking understanding of Métis health to develop culturally safe health programming and healthcare have a responsibility to engage with Métis women (Monchalin and Monchalin, 2018).

Métis Health Research

Systematic reviews of Indigenous health research consistently point out a predominant pan-Indigenous trend as far back as 1960 and up to 2009; most peer reviewed literature does not differentiate First Nation, Métis and Inuit findings and the Métis are persistently underrepresented (Furgal, Garvin, and Jardine, 2010; Kumar, Weshe, and McGuire, 2012; Wilson and Young, 2008). Second to pan-Indigenous literature, First Nation and Inuit specific research projects were most conducted and geographically, Indigenous peoples in the Prairies

and the West were the least studied (Furgal, Garvin, and Jardine, 2010). The 2006 Aboriginal People's Survey reported that the bulk of Métis people (87%) lived in the four western provinces and Ontario, with the majority living in Alberta (Statistics Canada, 2009). This population distribution coincides with the Métis homeland which includes parts of Ontario, BC, northern United States, Manitoba, Saskatchewan, and Alberta. In Alberta, there are 127,475 self-identified Métis of which over 64,000 are registered citizens of the Otipemisiwak Métis Government in Alberta (Métis Nation of Alberta, 2024; Statistics Canada, 2022). A case could be made that the paucity of Métis health research exemplifies a contemporary example of marginalization and colonial erasure by exclusion (LaVallee, Troupe, and Turner, 2016). Whether by population proportion or geographic distribution then, the Métis have been relegated to the road allowances of research. Furgal and colleagues suggest that the lack of Métis research reflects a lack of awareness and understanding of the Métis population in Canada (2010).

Métis Oral Health Research

Oral epidemiology relies heavily on national and regional aggregated First Nation, Metis, and Inuit census data to provide essential health and socio-economic information for comparison of Indigenous and non-Indigenous populations that allows for the quantification of health equity gaps (Smylie and Firestone, 2015). National and regional oral health surveys demonstrate significant oral health disparities experienced by Indigenous Peoples as compared to non-Indigenous Canadians (Cavin, 2015; Hussein, Bravo Jaimes, and Crizzle, 2021; Shrivastava, et al., 2019; Wallace and MacEntee, 2012). For instance, the Canadian Health Measures Survey 2007-2009 (CHMS) reported 89.2% of 6–11-year-old Indigenous children living off-reserve had caries experience with an average of 6.62 affected primary or permanent teeth compared to 55.2% of non-Indigenous children of the same age experiencing caries with an average affected

primary or permanent teeth score of 2.28 (Health Canada, 2010). Respondents of the CHMS were given the opportunity to self-identify under the broad category of either “Aboriginal” or “non-Aboriginal.”

Many Indigenous oral health studies focus more on prevalence and intervention for early childhood caries (Lawrence, 2010). Most often, aggregated Indigenous populations or specific First Nation and Inuit communities are studied. In Alberta, a population-based study of grade one and two children in the province’s two major urban centres was conducted that examined ethnic disparities and oral health outcomes. Among the ethnic groups studied, the population included a sample of combined First Nation, Métis, and Inuit children of whom 81.9% experienced caries with an average of 5.5 affected primary or permanent teeth, significantly higher than the White population included in the same study group (Shi et al., 2018).

A 2021 study examining the caries burden and Oral Health Related Quality of Life (OHRQoL) of First Nation and Métis children participating in the Manitoba Healthy Smile Healthy Child initiative was the first to specifically assess and include the oral health status of young Métis children in Canada (Lee, et al., 2022). Among the findings, the study reported that Métis children in the study are just as likely to suffer from severe early childhood caries than the First Nation children (42.9% v. 60.6% P=0.051) and that comparing the caries indices scores between First Nations and Métis children, (dmft 5.4 ± 5.5 v. 3.7 ± 4.8 and dmfs 15.8 ± 21.2 v. 11.2 ± 18.2), there was no significant difference between the 2 Indigenous groups (P = 0.083 and P = 0.22, respectively) (Lee, et al., 2022). The authors noted that this study was the first to assess the oral health status of young Métis children in Canada but that the results were representative only to the 4 communities studied and not to other Métis or Indigenous communities.

2.2 Conceptualizing Oral Health Inequity

Oral health inequity remains an intractable, global, public health concern increasingly recognized as a "wicked problem" (Baker, 2019) as coined in 1973 by Rittel and Webber on the difficulty of addressing problems of social policy and planning:

> "By now we are all beginning to realize that one of the most intractable problems is that of defining problems… and of locating problems (finding where in the complex causal networks the trouble really lies). In turn, and equally intractable, is the problem of identifying the actions that might effectively narrow the gap between what-is and what-ought-to-be" (159).

Although the development and advancements of oral health science and services sees Canadians of today enjoying far better oral health status and healthcare than Canadians of 50 years ago (Carstairs, 2022), the social gradients of disadvantage, deprivation and discrimination see those falling on either end of the gradient to be on entirely different scales than those in the middle (Freeman et al, 2020). In a recent 2023 Canadian Journal of Public Health commentary, *Oral Healthcare Disparities in Canada: Filling in the Gaps*, Levy and colleagues noted that a 2014 comparative analysis of oral healthcare systems in Canada, the United States, United Kingdom, France and Brazil (Neumann and Quiñonez, 2014) revealed

> "Canada still maintains the highest proportion of individuals with unmet oral healthcare needs, which may be explained by the disparity between Canadians who have the privilege of a high income and/or private dental insurance and thus do not hesitate to frequently access dental care, versus Canadians who cannot afford to visit the dentist routinely (or at all)" (142).

Perhaps the slow, ineffectual societal address of oral health disparity lies in the wickedness of a problem for which oral health researchers have been giving the 'right answers to the wrong questions' (Baker, 2019) and using a 'classical paradigm of science and engineering' to frame the 'social science' of oral health (Crowley and Head, 2017). Oral health research has evolved from a positivist paradigm of accumulating discrete quantifiable data and identifying relationships among variables to predict and effect oral health outcomes or behaviors (Baker et al, 2023). National and regional oral health surveys, oral health care expenditures analysis and descriptive research examining demographic differences of self-reported and clinically measured disease markers among targeted populations have been and remain the mainstay of conventional oral health research (Baker et al, 2023). The late 70s and 80s saw an increased look at individual characteristics and behaviors like dental anxiety, locus of control, smoking, dental attendance, and oral health knowledge as targeted variables on which to test oral health interventions alongside qualitative interviews by which to validate dental health questionnaires (Baker et al, 2023). The turn of the new millennium bore witness to the oral health field conceding that natural science alone could not address the complexity of lived human oral health experiences (Baker et al, 2023). Qualitative oral health and mixed methodological approaches looked to behavioral and social sciences to tackle the complexity of persistent inequities in oral health and access to care (Baker et al, 2023; Nicolau et al, 2023).

Certainly, a richer and more complex body of oral health literature is developing over time, but the progression of oral health research is not keeping pace with the need to evolve and incorporate new modes of thinking and doing to stem the tide of oral health disparity (Baker, 2019; Baker et al, 2023). It is time to 'think outside the box' and incorporate knowledge from other disciplines and experiential knowledge holders, interrogate and critique old assumptions,

develop new approaches and adapt or generate theories to support oral health researchers, practitioners, policy makers and the oral health of all (Baker et al, 2023; Fleming et al, 2023; Muirhead et al, 2020).

2.3 Oral Health Inequity and Indigenous Peoples

The predominant, global oral health deficit discourse has seen decades of research quantifying and qualifying the absence or presence of disease states that contributes to the stereotyping and stigmatization of Indigenous Peoples as described by Hyett and colleagues (2019). Failing to interrupt the colonial gaze, even progressive social determinants of health models and behavioral and cognitive-behavioral theories and models of behaviour and behaviour change, without consideration of historical, political or cultural contexts, do little to detract from a misconstrued focus on personal culpability according to homogenized individual risk factors in linear, causal relationships that further entrench social exclusion and perpetuate disparity (Fleming et al, 2023; Freeman et al, 2020; McNeil, 2023; Paris, 2019; Slack-Smith et al, 2023).

Understanding and addressing the disproportionate burden of oral disease carried by Indigenous people requires fulsome consideration of individual and community intersections with wider historical, social, economic, cultural, and political inequalities that contextualize the reality of Indigenous health and well-being (Adelson, 2005; Hedges et al, 2023). Upstream societal factors, systemic influences that privilege some and discriminate against others based on race and ethnicity, economic status, gender, age, and physical, behavioural, or emotional disabilities, all impact individual and community oral health experiences (Baker et al, 2023; Broomhead and Baker, 2023; Ramos-Gomez, Kinsler, and Askaryar, 2020).

There is a growing recognition among oral health researchers that health inequity is driven by power and privilege (Fleming et al, 2023). To date, there is little research to understand the complexity of what, how and why social, political, corporate, and behavioral determinants of health intersect and impact oral health behaviors, perceived needs, access, and utilization of oral health services among marginalized people (Baker, 2019; Baker et al, 2023; Freudenberg, 2023; Jamieson et al, 2020; Nicolau et al, 2023). Also, while there is, albeit scant, published work examining the impacts of racism, culture, access to health information, relational continuity, and the approach of health care providers on Indigenous people's attitudes and experiences in accessing oral care, the limited work in Canada is First Nation community based (Lawrence et al., 2016; Shrivastava, et al., 2019) which, by exclusion, marginalizes and silences the voices of Métis people's experiences of oral health.

Intersectional Theory and Indigenous Oral Health

Challenging the lens of dominant White male privilege and power, intersectionality, a social theory with Black feminist roots forwarded in 1989 by Kimberlé Crenshaw, is relatively new to the oral health research field. Becrying gender, race, and ethnicity as mutually exclusive, intersectionality effectively affirms the multiplicity of

> "bio-psycho-socio-political influences that impact and shape lives" (Baker et al, 2023:50).

This theoretical lens validates the reality of entangled

> "accumulation of lived experience that produces social identities which fundamentally defy quantification" (Baker et al, 2023: 50).

An intersectional approach to oral health research has great potential to contribute to research designs seeking a deeper understanding of the meaning and significance ascribed to

experiences and consequences of complex identities embedded in social elements of power, privilege, disadvantage, discrimination, and social exclusion (Baker et al, 2023; Freeman et al 202; Muirhead et al, 2020).

> "The meaning and significance of these social elements vary across time and space, depending on their social contexts, cultures and historical periods" (Muirhead et al, 2020: 465).

Well-disposed to Indigenous methodology, intersectional thinking looks to account for intergenerational social elements of colonial legacies that impact how Indigenous people live their oral health and is congruent with transformative decolonizing research designs that redress power imbalances through authentic community led collaboration.

> "Intersectionality challenges oral health researchers to adopt an inclusive approach to engage meaningfully with people who are typically marginalized and excluded from oral health research" (Muirhead et al, 2020: 467).

Muirhead and colleagues envision oral health research "embracing" intersectionality as a scaffold to produce descriptive *and* transformative research in community based, collaborative designs, collectively

> "revealing and reflecting upon 'what', 'why' and 'how' questions to uncover how intersecting identities affect oral health outcomes, inequalities and service utilization using theoretically driven approaches" (2020: 467).

They hold that intersectional, transformative, flexible, participatory research methodologies, committed to co-creation and co-interpretation of knowledge, would lead to impactful work that addressed community relevant issues (Muirhead et al, 2020).

Resilience Theory as Strength Based Indigenous Health Research

Resilience, a word derived from the Latin for 'jumping back up' and often defined as 'positive adaptation despite adversity' gained favour over the last century for its preventive and positive overtones in both every day and academic vernacular (Fleming and Ledogar, 2008; Luthar, 2006). Resilience theory has its roots in child psychology research of the 1960s and 1970s, studied then as a character trait identified as invulnerability or invincibility (Fleming and Ledogar, 2008). This original understanding lent itself to a flawed focus on personal culpability or deficiency though, which gave way to later recognizing resilience as resource potentiated.

> "Research has shown that, indeed, much of what seems to promote positive adaptation despite adversity does originate outside of the individual - in the family, the community, the society, the culture, and the environment" (Fleming and Ledogar, 2008: 8).

Resilience theory is strength-based; its focus lies in understanding the contextual processes of overcoming the negative effects of adversity or risk exposure (Zimmerman, 2013). An advantage to resilience thinking is that it starts by recognizing variation of individual responses to similar experience and goes about understanding the mechanisms of how and why contexts matter in hopes of guiding prevention and treatment (Rutter, 2006). An exploration of individual, family, community, and cultural factors that would mitigate risk and stressors produced an extensive list of empirically verified promotive factors that could foster resilience processes and outcomes (Fleming and Ledogar, 2008; Njeze et al, 2020). Promotive factors attributed to an individual are categorized as 'assets' and include positive intrinsic features such as goal orientation, self-esteem, and self-efficacy (Hiebel et al, 2021; Zimmerman, 2013). Similarly, contextual promotive factors are categorized as 'resources' and include extrinsic, social, socioeconomic, cultural, and environmental factors (Zimmerman, 2013).

Through an Indigenous lens, resilience is relational, existing between individuals, community, and culture, across time and in connection to the land (Gaudet, in publication; Njeze et al, 2020). Cultural continuity, a key promotive factor displayed by Indigenous Peoples, is

> "often defined as reestablishing expressions of Indigenous identity and belonging through connections with the land, environment, language and spiritual or cultural practices" (Njeze et al, 2020: 2002).

The promotion and renewal of spirituality, traditional language, activities, and healing practices have all been found to enhance resilience that positively impacts Indigenous health and wellbeing (Fleming and Ledogar, 2008; Njeze et al, 2020).

Extensive application of resilience in mental health has spread to other health related fields and can guide health promotion, prevention, early intervention, and treatment (Malhi et al, 2019). On the other hand, resilience theory is not without disadvantage. Resilience thinking has culminated in models of resilience that conceptualize the interaction of protective factors with risk and vulnerabilities but there is critique and caution in potentially misconstruing real-life complexities through simplistic linear models of risk (Fleming and Ledogar, 2008). Responsively, an earlier review of resilience literature relevant to Indigenous people recommended greater involvement of Indigenous researchers to further advance resilience theory through nonlinear worldviews (Fleming and Ledogar, 2008).

Intersectional Resilience Framework

Given the import of social, structural, and behavioral factors that resilience thinking attributes to adaptive wellness, it is interesting that resilience theory has not fully acknowledged intersectionality in its approach (Njeze et al, 2020). For example, while studies on elements of

culture as resources for resilience and wellness among Indigenous youth are trending, alone this work may overlook

> "complex connections to, and relationships with, other resilience-promoting factors and processes. The concept of intersectionality opens up possibilities for studying interactions across the different individual and social resilience-promoting factors, ensuring researchers remain focused on relationships and interactions rather than specific factors and isolated outcomes" (Njeze et al, 2020: 2002).

Current intersectional health research addresses multiple social identities such as race, class, gender, and ability as they interrelate across contexts and time to produce, propagate, and protect inequity and unjust power dynamics (Bauer, 2014; Njeze et al, 2020). Like resilience theory, intersectionality has a problematic gap. Alone, intersectional theory may neglect the positive aspects of self, family or community that reinforce agency, self-determination, resistance, and wellness practice (Njeze et al, 2020).

> "By informing resilience research through an intersectional lens, there is an opportunity not only to better expose multiple layers of inequity and disadvantage occurring from intersecting forms of oppression but also to encourage the inclusion of complex, strengths-based understandings of individual and social resilience promoting processes" (Njeze, 2020:2003).

Njeze and colleagues propose that together, an intersectional resilience framework can offer an enriched, inclusive lens to inform study rationale and methodological choice of Indigenous health research (2020). Foundationally, intersectional resilience theorizing can advance a nuanced understanding of the multidimensional, heterogenous, individual, and

sociocultural lived oral health experiences, beliefs, needs, interests, and capacities of diverse Indigenous groups and uncover structural power dynamics that shape everyday resilience processes and health outcomes (Bauer, 2014: Njeze et al, 2020). In turn, this opens future avenues of inquiry to consider the relationships and potential of multiple approaches to family and community sociocultural programming and structural interventions that support and augment individual health outcomes (Njeze et al, 2020).

2.4 Summary

The Métis people comprise one-third of the Indigenous population in Canada with distinct historical, political, social, economic, and cultural contexts that can impact determinants of health in their communities. Métis specific, community-based health research, including oral health, is needed to facilitate meaningful change and drive evidence-based advocacy and community self-determination. While there are some indications in the literature that Métis people face disparate oral health outcomes on par with First Nation and Inuit peoples, these studies are limited in number.

Métis women hold culturally important roles in the transmission of knowledge surrounding health and wellbeing (Anderson, 2016; Monchalin et al, 2019). Drawing on intersectional theory (Crenshaw, 1989; McGuire-Adams, 2020) finds mutual support in engaging with, remembering, and connecting with women's stories of lived oral health experiences. Privileging the voice of Métis women in sharing their unique local, historical, and contemporary knowledge is key to understanding and addressing the disparate oral health outcomes Métis people share with First Nation and Inuit people in Canada.

Intersectional resilience theorizing is conducive to research inquiry surrounding

Indigenous health inequity. Such a framework has potential to address Indigenous oral health disparity by fostering participatory, relational, and transformative community-led research projects considering heterogenous, individual, and socio-cultural resilience processes and contexts of oral health beliefs, attitudes, self-identified needs and service experiences.

CHAPTER 3: RESEARCH DESIGN AND METHODOLOGY

3.1 Methodological Considerations in Indigenous Health Research

December 2023 marks the eighth year since the release of the Truth and Reconciliation Commission's (TRC) final report and 94 calls to action meant for various Canadian sectors to review, reflect and improve settler-Indigenous relations (Bauer et al., 2022; TRC, 2015). Seven of these calls to action address Indigenous health inequities and seek to redress the practice, research, and education of healthcare professionals (Bauer et al., 2022; TRC, 2015). The predominant biomedical, deficit-based nature of current health research quantifies and qualifies health assessment based on the absence or presence of disease (Hyett et al., 2019). Such inquiry lends itself to a demographic analysis of health outcomes that singles out populations experiencing health disparity presumably to identify failing or insufficient system-based responses to unmet health needs (Hyett et al., 2019). Ongoing health research comparing Indigenous peoples to non-Indigenous people in Canada perpetuates a deficit discourse that paints Indigenous communities in disparity, deprivation, disadvantage, dysfunction, and difference (Walter and Andersen, 2016). In turn, healthcare practitioners "digest and apply" such peer-reviewed literature that not only risks the cultural safety of Indigenous people seeking care but also fails to result in transformative health interventions" (Hyett et al., 2019:105).

Decolonizing Indigenous Health and Oral Health Research

Responding to such criticism, health disciplines have begun to engage Indigenous people in decolonizing, community, and participatory-based research studies. Such work utilizes a mixture of Indigenous and indigenized, adapted Western research methods like photovoice, digital storytelling, conversational methods and focus groups in the form of talk circles.

Innovative "mixed method[1]" studies attempt to align with principles of Indigenous research methodology (IRM) with varying levels of success (Botha, 2011; Drawson, Toombs, and Mushquash, 2017; Hyett et al., 2023; Kennedy et al., 2022; Lee et al, 2020). For example, a systematic review of pediatric Indigenous health research in Canada reported Indigenous participation in 5% of studies prior to 1980 rising to 60 % between 2011 - 2020 (Hyett et al., 2023) whereas a scoping review of maternal health research found that 71% of 441 studies between 2000 - 2019 did not report any Indigenous involvement in the research process at all (Patterson et al., 2022). While these findings may be limited by inconsistent reporting practices, a systematic review of Indigenous research methods concluded that a lack of Indigenous engagement or partnership resulted in ineffectual data that did not confer benefit to the communities of focus (Drawson, Toombs, and Mushquash, 2017). A review of global maternal health literature likewise reported that 95% of articles did not report sharing their findings with communities, 87% did not report any benefits to the Indigenous people participating in these studies and only 12% of the articles acknowledged colonialism to contextualize findings (Patterson et al., 2022). A scoping review of Indigenous health research in Atlantic Canada, points out a plateau in the number of articles reporting community participation between 2000 - 2020 (White et al., 2021). Drawing from the above findings then, it can be argued that studies that adapt Indigenous methods into Western paradigms are susceptible to disregarding Indigenous research principles by sidelining Indigenous voices and values.

The Reemergence of Indigenous Research Methodology

Foundational, critical scholarship like that of Maori scholar, Linda Tuwhai Smith (Smith, 1999) in *Decolonizing Methodologies,* proposes Indigenous researchers reclaim Indigenous

[1] Mixed method taken here to be a blend of Western and Indigenous research methods.

research practices to propel communities out of the realm of being known and to assert themselves as the knowers they have always been. Indigenous research methodology (IRM), paradigmatic research that prioritizes Indigenous worldviews rooted in local cultural and community epistemological frameworks, is central to this reclamation (Absolon, 2022; Chilisa, 2012; Kirkness and Barnhardt, 1991; Forsyth et al., 2022; Kovach, 2009; Smith, 1999; Wilson, 2008). Indigenous knowledge systems applied with collective, participatory action for social change prioritize community self-determination and cultural autonomy, known to improve community health while addressing health disparities (Israel et al., 2005; Minkler and Wallerstein, 2003). Through IRM, oral health researchers can create meaningful, lasting partnerships that critically resist and uncover socio-historical conditions and enduring colonial practices that continue to impact oral health outcomes and access to oral healthcare delivery.

3.2 Foundations of Indigenous Research Methodology

Indigenous research methodology (IRM) is rooted in the diverse ways that Indigenous people are in the world, how they think about the world and what governs interactions with that world, otherwise known as epistemology, ontology, and axiology (Kovach, 2009; Wilson, 2001). Methodology has been explained as the *thinking* and the *doing* of gaining knowledge, outlining the belief system and methods framing research design and process (Kovach, 2021; Wilson, 2001). Given that there is a myriad of Indigenous Peoples in the world, the operationalization and conceptualization of Indigenous paradigms premised on these four philosophical elements, epistemology, ontology, axiology, and methodology, vary by country, culture, community, and researcher (Walter and Andersen, 2016). Yet embedded in this diversity of Indigenous worldviews are commonalities shared across many of the culturally, linguistically, and politically distinct subpopulations of Indigenous Peoples in Canada.

Relationality

Relationality is a core ontological premise of Indigenous knowledge systems; everyone and everything is connected; existence is and through relatedness (Barlo et al., 2020; Tynan, 2021; Wilson, 2001). Indigenous ontology is premised on relationships so much so that as Indigenous scholar Shawn Wilson described,

> "reality is relationships or sets of relationships*"* (2008:73).

Indigenous ways of being are intertwined in an exhaustive web of relationality that includes humans, other than humans, the land, natural elements, time, space, and spiritual entities (Tynan, 2021). Indigenous epistemology understands that knowledge is relational, we come to know in relation to self, others, nature, and the cosmos, through time, in this life and beyond (Wilson, 2001; Windchief and San Pedro, 2019). Such knowledge systems generate holistic, collective, and cumulative genealogies of relationships and teachings that are passed on intergenerationally through oral traditions, mentorship, teaching, shared experiences, and storytelling (Absolon, 2022; Wilson, 2001). The axiology, or ethics and values that govern Indigenous knowledge systems are relational as well. The axiological premises of Indigenous thought ethically and spiritually ground the research in relational accountability.

> "So your methodology has to ask different questions: rather than asking about validity or reliability you are asking how am I fulfilling my role in this relationship? What are my obligations in this relationship? Axiology or morals need to be an integral part of the methodology so that when I am gaining knowledge, I am not just gaining in some abstract pursuit; I am gaining knowledge in order to fulfill my end of the research relationship" (Wilson, 2001:177).

Kinship

Conceptually, Indigenous kinship is rooted in relationality. Connection to family, community, Nation, land, and time is key to Indigenous knowledge systems. According to Cree and Métis teaching for example, this is known as *wahkotowin*; everything and everyone are our kin, humankind, plants, animals, sun, moon, stars, and elements and we are accountable to all of these relationships (Campbell, 2007; Steinhauer, 2002; Wildcat, 2018). Among Africans in South Africa, the *ubantu* worldview and African adage

> "I am we; I am because we are; we are because I am" (Chilisa, 2012:103)

expresses this same interdependence and connectedness of all things living and nonliving which privileges the collective while also allowing individual growth. Another North American Indigenous adage, "*all our relations*" recognizes and honours a holistic and inclusive kinship web as well (Wilson, 2001). Principled and ethical research framed within such a paradigm not only welcomes deep relationships between researchers and knowledge holders, in fact, it demands them. Intimate and mutual relationships build on deep trust, dialogue, and reciprocity to generate rich, co-created insights and understandings (Daniels et al., 2021; Kovach, 2021; Simpson, 2017). Without our ways of doing to frame research involving Indigenous people, the work becomes damage centred (Tuck, 2009). The morality underlying ethical and relational Indigenous knowledge systems keeps us connected and grounds research ideas in ways that call us to honour those relationships reverently. The reflexive and self-reflexive rigour of answering to kinship and the principles of relational accountability serve as criteria and measure of authenticity and validity in Indigenous research methodology (Wilson, 2001).

3.3 Principles of Indigenous Research Methodology

There is no universal prescription for how to do Indigenous research methodology; its application is fluid and responsive to the community, culture, people, and relationships involved. However, an Indigenous paradigmatic approach, relational accountability, privileging Indigenous voices and having a decolonizing aim are all important and distinguishing features of research with Indigenous people that is done *in a good way*[2] (McGuire-Adams, 2018; Wilson, 2001). These principled tenets resist epistemic racism and represent a shift in Indigenous research practice from mere consultation or tokenism to veritable processes of co-design, delivery, and dissemination (Hedges et al., 2023).

IRM is Responsible

For the researcher, preparation to facilitate flexible, intuitive, and purposeful research relationships requires work that goes beyond the typical literature review, research design, and development of tools or interview protocols. The deeply relational nature of this work requires holistic personal and interpersonal preparation (Kovach, 2019). This essential work involves reflexivity and positioning that demonstrates an understanding of how the researcher's spiritual, social, cultural, economic, and historical background informs their motivations, actions, and interpretation. Deep listening, from within and without, is integral when approaching research through an Indigenous paradigm (Byrne et al., 2021; Wilson, 2008). Building responsible, trusting relationships with Indigenous communities and with the research means acquiring self-knowledge and contemplating one's own web of kinship emotionally, physically, intellectually, and spiritually (Absolon and Willett, 2004). Interpersonal preparation that is rooted in

[2] "in a good way" is an expression among Indigenous communities that denotes the honoring of traditions and spirit (Flicker et al, 2015)

Indigenous understandings of relationality and kinship recognize the responsibility and accountability of actively living up to all relationships. This goes beyond reflexivity alone but is an ongoing process of internalizing a lived belief on which mutual trust and understanding is built (Wilson, 2001). Practically speaking, Indigenous people cannot trust a researcher if they do not know who they are, who their people are and who and to what they are accountable. Embracing the responsibility of such preparation is critical not only in creating good research relationships but also integral to the entirety of research processes that can then demonstrate the validity of work not written vicariously or created in a vacuum (Absolon and Willett, 2004).

IRM is Reciprocal

Authentic and equitable sharing of power and knowledge in IRM ensures the community and the participant knowledge holders benefit throughout the research process, outcomes, and presentation (Le and Gobert, 2015). Reciprocity in research begins with co-creative conversations that uncover community driven questions and purposes that continue throughout the research process and presentation. Knowledge translation developed by purposeful co-planning and co-production addresses how best and with whom to share the outcomes of the research project, acknowledging that in so doing, the research knowledge itself lives on and affects relationships for generations to come (Mcdonald and Paul, 2021; Wilson, 2008). The final arbiters of a project's value are the community, the knowledge holders, and then the researcher and academy (McGregor, Restoule, and Johnston, 2018).

IRM is Respectful

Respect involves recognition of the ownership, control, access, and possession of research and not coming to the community with an agenda. Authentic partnering and power sharing in IRM assumes that Indigenous people fully participate in the research process and

prioritizes Indigenous voices as the source of knowledge creation (Snow et al., 2016). Interpersonal preparation and humble recognition of your role as a learner is essential (Snow et al., 2016). Time must be spent getting to know the participants, the land, the protocols, and traditions particular to the target community. Indigenous codes of conduct, deep humility and the practice of gratitude run deeper than merely asking permission, obtaining consent, and offering thanks (Absolon, 2022). The importance of elders along such a research journey transcends time; the knowledge they share can be gifted here in this present life and long after they have moved onto the next (Absolon, 2022). In IRM, researchers welcome and accept invitations to visit, to be taught, and to participate in community gatherings, cultural events, ceremonies, and spiritual exercises as essential groundwork on which respectful relationships are built. Indigenous research takes time that is not relegated to just a few interviews. Respecting the knowledge that exists within community is demonstrated through a commitment to collective voice, ongoing relationship building, maintenance, and giving back that endures (Kurtz et al., 2017; Steinhauer, 2002).

IRM is Relevant

From inception onwards, research that is relevant, meaningful, and beneficial to Indigenous peoples prioritizes community identified needs and questions. Knowledge translation goes beyond presentation in academic journals, ensuring that research does not remain a conversation of 'us' (academia) about 'them' (participants) (Mackenzie, et al., 2018). Part of this power equalization involves critical attention to prominent and colonial worldviews reflected in language usage. Specifically, demystifying research language contributes to equitable relations and makes research processes meaningful to everyone involved (Snow et al., 2016). Some scholars engaging with Indigenous research methodology strategically choose to use terminology

that is metaphorically relatable and respectful to Indigenous processes of knowledge seeking (Absolon 2022). For example, based on the traditional notion of berry picking as a searching and gathering practice, Indigenous scholar Kathleen Absolon understands data collection as knowledge gathering, and data analysis as making meaning (Absolon and Willett, 2004). Research participants and researchers are similarly known as knowledge holders and knowledge seekers learning where, when, and what to pick and how best to make use of the gathered bundles of food and sustenance (Absolon 2022). Such metaphorical thinking replaces research jargon and provides a relatable framework for discussion that makes authentic participation more accessible (Absolon, 2022; Chilisa, 2012; Snow et al., 2016).

3.4 What is Methodology?

'What is research methodology'? Walter and Anderson point out that although this question and its counterpart, 'what is Indigenous research methodology,' seem straightforward, articulating these answers is no easy task (2013). While simultaneously recognizing that prevailing methodology discussions in the literature gloss over, avoid or are purposefully vague in their offerings, they point out that without clear understanding of methodology and methods it is even more difficult to assert and differentiate Indigenous research methodology (IRM) (Walter and Anderson, 2013). Walter and Anderson refer to their earlier writings, where they

> "positioned methodology as the theoretical lens or worldview through which to understand, design and conduct research" (2009:42)

but report that they were never really satisfied with the vagueness of 'worldview' or 'lens.' Determined to add to and clarify student and researcher understanding in this area, Walter and Anderson present a conceptualization of all research methodology, qualitative, quantitative, or

Indigenous. They combine a researcher's social position, epistemology, ontology, and axiology as a critical determinant of methodology that they refer to as the "research standpoint" (Walter and Anderson, 2013:45). In turn, the research standpoint influences the theoretical framework and the methods which, brought all together, constitute methodology.

Despite the discomfort and difficulty in elucidating methodology, its philosophical underpinnings are present even when not contemplated and addressed; as is often the case in quantitative research (Anderson and Walter, 2013). In the case of qualitative or mixed method approaches, methodology, theoretical perspective, and methods may converge and coalesce into the work perfunctorily or silently (Mayan 2009). Such omission does not deny their pre-existence and fundamental influence on the entire research process but in fact, may attest to dominant settler intersections that are not acknowledged (Anderson and Walter 2013:45).

I am also reminded of Maria Mayan's, *Essentials of Qualitative Inquiry,* which I read for my first graduate-level course in January, 2021. She discusses theoretical divisions among interdisciplinary qualitative research and adds that clarifying one's ontology and epistemology is only possible by understanding and familiarizing yourself with various philosophies and theories like critical theory, feminism, postcolonialism, postmodernism and poststructuralism (Mayan 2009: 25). Besides the breadth of work a person could get lost in when delving into these theoretical perspectives, she warns that these categories are also not mutually exclusive, further complicating this exercise. I remember feeling overwhelmed as I skimmed through these theoretical elements and perspectives in Mayan's text, not only wondering how I could keep it all in my head but wondering how Indigenous research "fit" into these groupings, wanting to find comfort in category and prescription. As I continued my research journey, the work of Indigenous scholars continued to spur me on, encouraging me to look closely at my thinking, my

social position, and experiences as an oral healthcare provider for 30 years, my ways of being, knowing and doing and to grapple with defining these as a Métis woman, student, and researcher.

3.5 Keeoukaywin Methodology

Wilson describes methodology as

> "how you are going to use your ways of thinking (your epistemology) to gain more knowledge about your reality" (2001:175).

'Cerebral' and 'heartfelt' work of Indigenous researchers (Kovach, 2009) from communities and cultures around the world have resulted in numerous, responsive, and creative ways of operationalizing and conceptualizing diverse Indigenous paradigms into relevant and meaningful research methodologies (Walter and Andersen, 2016). In her article, *Keeoukaywin: The Visiting Way - Fostering an Indigenous Research Methodology,* Gaudet 'regenerates' and 'reclaims' the knowledge and practice of Métis visiting as

> "a practical and meaningful methodology that fosters *milo pimatisiwin*, living and being well in relation" (2019:47).

Keeoukaywin, Michif Cree for 'visiting' enacts the relational accountability of an Indigenous paradigm as a reciprocal and respectful way of building and maintaining relationships. Visiting has deep cultural, social, political, educational, economic, and spiritual significance to the Métis people (Flaminio et al., 2020; Gaudet, 2019). It is often enacted within kinship community systems as

> "a way to look after ourselves and our relatives" (Gaudet et al, 2022:323),

as a way of learning, gathering, creating, and exchanging knowledge and values that facilitates collective decision making. The multilayered relationality of visiting upholds personal autonomy

and fosters an ethic of care and intimacy between visitors (McDonald and Paul, 2021, Tuck et al., 2023).

Keeoukaywin as a Métis methodology flows from the Métis people's love of family; kinship ties are integral to the transmission and sharing of traditional and contemporary knowledge (Flaminio et al., 2020). *Keeoukaywin* fosters an ongoing and overarching commitment to the mutual respect of each person's capability and vulnerability and supports collective and individual self-determination (Gaudet, 2019; Smith 2016; Tuck et al., 2023). The processes, principles and protocols of visiting enact the mutuality and sovereignty built into Indigenous cultures being constitutive of the relational principles of responsibility, reciprocity, respect, and relevance in Indigenous research methodologies (Gaudet et al., 2020; Kirkness and Barnhardt, 2001). Such mutuality is also corrective and transformative of settler-colonial, researcher-participant power imbalances that can be masked by albeit well intentioned work to help marginalized peoples (Gaudet et al., 2020; Young, 2003).

Keeoukaywin informs every aspect of my graduate research project, from idea inception to knowledge presentation. To appreciate the rich scaffolding on which this methodology is built, it is important not to overly define the breadth, depth and variation of how Indigenous people practice visiting. The when, with whom or what, where and how visiting is enacted should not be nailed down or trademarked (Tuck et al, 2023). Visiting is as animate and holistic as the Indigenous knowledge it creates being as spiritual, embodied, and instinctual as it is cognitive (Kovach, 2021). I have come to recognize visiting as extraordinary, physical, emotional, and spiritual. As Indigenous people, there is reverence in recognizing visitations and visiting with *all our relations* (Absolon and Willett, 2004; Tuck et al, 2023). Knowledge is sought, gifted and co-created through self in relation to the animate and inanimate world, to community and kin, to

place and land, over the folding of time past, present and future, and is an interdependent and collective process of remembering, claiming and visioning together within a web of kinship not confined by human bonds alone (Kovach, 2021; McDonald and Paul, 2021). What we know also comes via intangible bonds created by visiting within a non-human centric world (Kovach, 2021). For instance, kinship also extends to the relationship between the knower and the knowledge, between the researcher and their research; research and knowledge themselves then being kin (Barlo et al, 2021; McDonald and Paul, 2021).

Conceptualizing the Visiting Way as Métis Methodology

While the visiting way is not prescriptive, and as Gaudet states, not grounded in Western notions of 'relationship building' it is community responsive (2014, 2019). To many Métis people, visiting occurs within one another's homes and centres around sharing tea, creating multi-generational safe spaces to talk and listen to one another, often including tasks like beading, sewing, or canning (Gaudet et al., 2020). This is true to a strong cultural belief in learning by doing. The form that a visiting methodology takes is just as diverse as the Métis family kitchen. Design, furnishing, pots, pans, dishes, food, smells, and pantries - no two kitchens are ever the same. The space depends on the host, who is coming to visit and what work is going to be done. What is important is that all visitors share stories, generate, and co-create knowledge in dialogic participation (Gaudet, 2019; Kovach, 2019).

For me, the academic abstraction of contemplating epistemology, ontology, axiology, and methodology has always been a challenge regardless of a qualitative, quantitative, or Indigenous approach. When conceptualizing *keeoukaywin* as a research methodology my mind sought clarity through concrete lived understanding. Remembering the many visits, sounds, smells and flavours of my grandmother's home and table, I had a sudden moment of clarity and saw the *keeoukaywin*

methodology as clear as I could see my grandmother sitting at her table braiding, her tea always beside her at the ready.

Figure 3.1 My grandmother, Millie Lacombe, braiding a rug at her home in St. Paul, Alberta, circa 1972

Lii Taab - The Kitchen Table

"I've always been a kitchen table person" my mom says as she knots my needle and thread. Earlier she laughed as I struggled to tie off the end of my thread, "I'm so sorry I never taught you to knot a thread before, my daughter." It is bittersweet that it has taken me 54 years to slow down and visit with her and Grandma now, a loss that I own but not too late to change. Sitting at her table, Mom has been teaching me to braid rag rugs; at kitchen tables of days now gone, her mother and older sister braided innumerable rugs to support and feed their families over the years. "I like to work with colours, but when you have to put food on the table, you just use what you have," she murmurs as we try to decide what colors to use in our co-creation. On Mom's fridge, she has six small vintage photos, one of which is my grandma outside on a wet, snowy day. She is standing by her brother-in-law's car, a rug rolled up under her arm, catching a ride to town to sell one of her prized creations. My mother's kitchen and my parents' home has always grounded me, but now I am reclaiming who I am sitting together with Mom at her table.

> "To situate ourselves through Grandmothers means that we understand ourselves, as part of the traditions that shaped us. We regenerate the tradition as we live it and it has created us" (Gaudet et al, 2022:323).

Métis scholar, Sherry Farrell Racette, points to the embodied practice of "kitchen table theory", as it too, unfolds a methodology of deeply reflective, co-generative research where there is room for everyone at the table (Racette, 2022). Her recent article, *Kitchen Tables and Beads: Space and Gesture in Contemplative and Creative Research*, reminds me too of my community at *lii taab*, Michif for 'the table' (Gaudet and Rancourt, 2024). *Lii taab* has become a space where Métis scholar Cindy Gaudet mentors and invites Michif students like me to support, grow and transform Métis research praxis in co-creative relation to one another. It was with these colleagues at *lii taab* that I shared a conceptualization of *keeoukaywin* as I have come to understand it and where, in true mutual learning and creating, it has become part of us (See Figure 3.2).

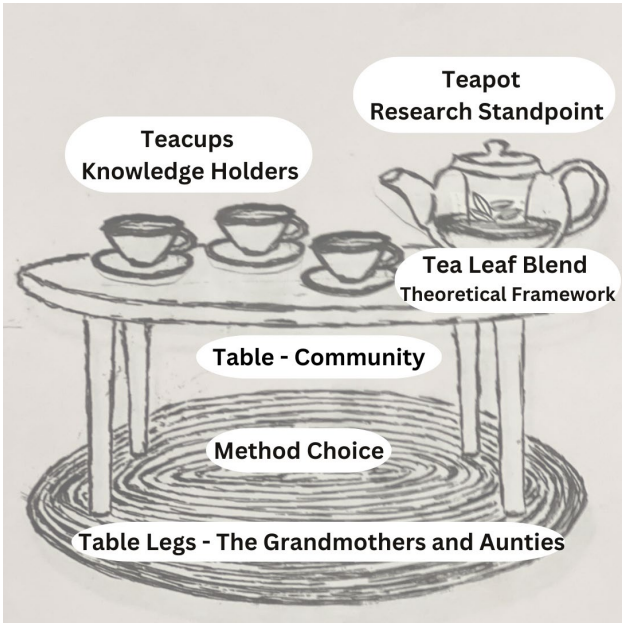

Figure 3.2 Conceptualization of a *Keeoukaywin* Methodology

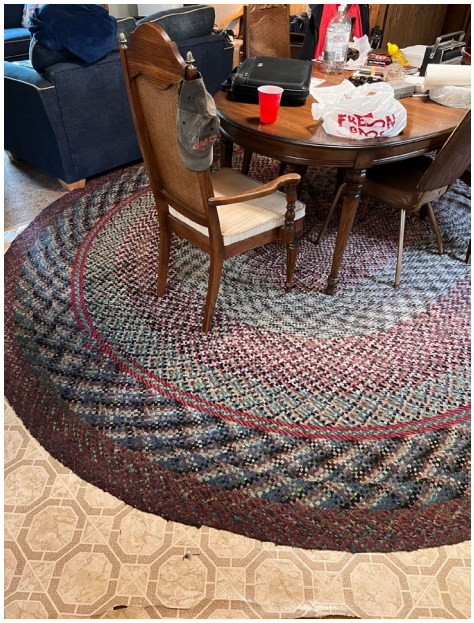

Figure 3.3 Large kitchen rug made by Grandma for her oldest son's wedding over 70 years ago

Initially, when I had set out to apply Walter and Anderson's conceptualization of methodology to *keeoukaywin* I concerned myself first with how to illustrate the connections they describe between research standpoint (researcher social position, epistemology, ontology, and axiology), theoretical framework, and method (2016). I began with a rudimentary stick drawing of a picture I had of one of my grandmother's rugs in the kitchen at my cousin's cabin, a wonderful place to visit over tea or coffee (See Figure 3.3). My husband adapted this for me as I explained how this familiar room could represent research standpoint, theoretical framework, and method choices of "the visiting way" (Gaudet, 2019). I shared the beginnings of this conceptualization with my colleagues at *lii taab* and we continued to vision and build this understanding rooting it deeply in Métis women's kinship praxis.

Teapot. I have rarely been for a visit and come across the exact same teapot in more than one home. To me, a teapot can hold a glimpse into our diversity and commonality as a people. Whether contemporary or traditional, teapots speak to purpose, personality, and history, both creating and holding the memories of Métis kinship. The handle of the teapot I recognize as the researcher and their social position, attached to the main body; ways of knowing, being and doing that hold space for the collective knowledges and memories of the community.

Interestingly, when I think of serving tea in my home, there are multiple options for different purposes. I look at my mom's Royal Albert teapot she gave me, tucked safely away in my china cabinet for special occasions. The red one on my kitchen window ledge looks modern with its sharp-edged handle and spout, a diffuser held in the body to conveniently hold loose tea. When I am alone, I steep and sip with my Yeti Rambler held by both hands, a bulky vessel reminiscent of the Mason jar Grandma drank her tea from every day. In similar fashion, as knowledge seekers, researchers consider methodological choices according to our purpose and

who we will be working with. In *keeoukaywin*, the teapot of choice is also dependent on who is coming to visit.

Teacups. My grandmother loved teacups. In addition to her notoriety as a talented braided rug artisan she had hundreds of unique cups and saucers that she hunted for in secondhand shops and garage sales in addition to the many gifted to her from friends, family and her sons who served overseas (See Figure 3.4). She had china cabinets throughout her home and every space on her walls that could hold a nail, held a porcelain treasure. The china cabinets sometimes held tea sets, groups of four to six cups adorned in the same pattern but, her collection was varied and eclectic. It was a remarkable sight and a very tangible metaphor for the kaleidoscope of human individuality and diversity. In the same way, every visitor can bring unique experiences, knowledge, and beauty to a kitchen table visit. Enacting *keeoukaywin* in research, knowledge holders come to *lii taab,* each contributing distinctive perceptions that lead to rich, contextualized meaning.

Tea Blend. Inside the diffuser, the tea blend steeps as concepts and theories forming a project's theoretical framework. Over the years I have sipped of and offered many teas; blends of medicines prevent illness and bring healing and comfort. Generations old, these remedies are far more than recipe or prescription and their healing is deeper than any physical manifestation alone.

"Keeoukaywin helps 'dig up our medicines'," says Gaudet (2019:53), pointing to and echoing Kim Anderson's work, *Life Stages and Native Women: Memory, Teachings, and Story Medicine.*

> "The recovery of our peoples is linked to digging up the medicines of our past. Knowing our histories is an integral part of recovery for us as Indigenous peoples and for our communities in general" (Anderson, 2011:4).

These histories hold knowledge and understanding, the lenses through which we approach life and learning.

Figure 3.4 My grandmother, Millie Lacombe with some of her teacups shown behind her.

Lii Taab - The Table. One commonality of the kitchen table is that it is often in the warmest room in the house with the stove, oven, or fire nearby, and invariably the best flat surface on which to accomplish whatever task is at hand (Racette, 2022). The diversity of Indigenous communities with whom knowledge is co-created and generated is reflected by the various forms, shapes, and sizes of kitchen tables everywhere.

Table Legs - The Grandmothers and the Aunties. The resilient strength and collective knowledge of our ancestor Grandmothers and Aunties are foundational to Indigenous communities, as represented by the legs of the table.

> "When I was in the early stages of researching, Mosôm Danny told me that "women were the centre and core of our community and our nation. No nation ever existed without the

fortitude of our grandmothers, and all of those teachings have to be somehow recovered" (Anderson, 2011:162).

Braided Rug. Braided Métis rugs are constructed from used, discarded materials, old bedding, t-shirts, "anything," Mom recalls Grandma saying, "that you could rip or cut into strips." Grandma employed various means of gathering her supplies to create her rugs. She loved to shop at thrift stores and, jokingly, was not too shy to ask for the clothes off someone's back. "Hey, I need that color," Grandma would say to people as she pointed at their clothes with a gleam in her eye. Friends and family used to stop in for a visit, often dropping off bags of old clothes and sheets for her to separate, sort, and test for colour, tension, and workability. Practically speaking, used materials are not only cost saving but, being well worn, are shrunken and unlikely to weep any dye when wet. This takes on even greater meaning considering these fabrics contain more than metaphorical memories and experience; in some instances, there may even be DNA embedded in the fibers. The wear and tear of experience in such rags carries people's lives and stories; deciding on appropriate research methods to unravel and uncover experiential knowledge is key to method choice in the *Keeoukaywin* methodology (Gaudet, 2019).

Like other Indigenous research methodologies, the visiting way is responsive and flexible according to the project and the community (Gaudet et al, 2020). The axiological assumptions of respect, relevance, reciprocity, and responsibility of *keeoukaywin* is synchronous with a multitude of culturally appropriate research tools including visiting, traditional teaching and protocols, sharing circles, dreaming, storytelling, ceremony, and vision quests while certainly not excluding Western methods like participant observation, interviews, focus groups, photovoice or thematic, content, narrative and discourse analyses to name a few. It is the inquiry and contextual

journey of each project that determines what research methods are chosen in an Indigenous paradigmatic approach. These choices are rightfully limited primarily by whether their use upholds the ethics of Indigenous ways of doing and obligations to relationships and community (Wilson, 2008).

3.6 Summary

Rooted in inherently relational, holistic paradigms, Indigenous research methodologies, like presented here, facilitate rigorous, accurate, community relevant and trustworthy co-creation of knowledge that is representative of all those involved in the research process including the researcher, the participants, the community, and the knowledge itself. Indigenous research paradigms are rooted in distinct epistemological, ontological, and axiological knowledge systems. Indigenous methodologies guide research that is congruent with Indigenous worldviews and are culturally responsible, reciprocal, relevant, and respectful in conception, design, method, analysis, reporting and translation.

CHAPTER 4: ENACTING *KEEOUKAYWIN* AND BRAIDED RUG MAKING TO CO-CREATE MÉTIS WOMEN'S PERSPECTIVES OF ORAL HEALTH

4.1 Inquiry Conception and Design

Visiting anchors us to a web of relationality that instills a sense of self and belonging that spurs responsibility to family, to community and to the land (Gaudet, 2019; Kovach, 2005). The many layers of relationship to my identity, my profession, graduate education, my family, my home, and to all the individual, community, and organizational relationships in my network, have not only spurred this graduate research journey but have shaped its inquiry and determined its questions and objectives.

What I have come to know is that I have been visiting the oral health of Métis people long before embarking on this graduate research journey. The intersection of my professional, lived reality of studying and practicing dental hygiene for 30 years and my Métis identity, started an academic exploration and dialogic pursuit of finding myself and my nation in an oral health arena that does not see, recognize nor understand Métis people and their cultural and relational approach to research. When I moved back home, after practicing in a large urban centre for the first half of my career, this pursuit was reignited by reestablishing my connections to the land and to the Métis, both personally and professionally.

The spaces I have walked in my community afford me many relevant and critical visiting opportunities. As a Métis woman and healthcare provider, I earn people's trust by seeing the people I meet and serve as my relations; people who see that you care deeply feel freer to share deeply. I have been active in volunteering with the Otipemisiwak Métis Government of the Métis Nation in Alberta (OMG-MNA) health department. The OMG-MNA recognizes the importance

of oral health promotion and has collaborated with me to offer oral health assessments at numerous health forums and annual general assemblies over the years. In these places where we gather, celebrate, promote wellness, build community, and make decisions, I have heard from Métis citizens across the province.

Additionally, as Métis, I value and respect my Elders and the knowledge they carry. Oftentimes Indigenous researchers seek the wisdom of an Elder to walk with them on their research journeys; these relationships are intrinsic to Indigenous research methodology given that research is not compartmentalized apart from our everyday lives. Early in my graduate program, I approached a trusted community Elder, Auntie and friend to be my cultural advisor, mentor, and guide. Her wisdom and counsel help keep me grounded to my relational responsibilities. I made an offering and enduring commitment to her that day, integral to my methodological choices, which will last long after this academic portion of my journey. She has an in-depth understanding of Métis history, Métis family genealogies, protocols, and Métis knowledge. Our visits over these last couple of years have been filled with laughter and stories, remembering who we were and are as Métis people, and renewing who we want to be. This remembering and visioning is part of the self determination that ingrained in Indigenous research methodology. Through the social construction of knowledge and lived oral health experiences of Métis patients, friends, and families and in all this visiting, we resist erasure and take back our sovereignty, informing change that will see the Métis emerge from the margins of oral health disparity, research, policy, and service provision.

4.2 Where We Live and Work

This research project takes place in District 12 of the Otipemisiwak Métis Government of the Métis Nation in Alberta (OMG-MNA) which encompasses, but is not limited to northeastern Alberta's Lakeland, areas surrounding Cold Lake, Bonnyville, St. Paul, and Elk Point. These communities and surrounding areas form part of my kinship network and represent long-standing generational ties to the land that my family calls home.

4.3 Meet the Knowledge Holders

I am not the first researcher in my family. Over and before time was measured, our matriarchs have been investigating, seeking, creating, and responding to their changing physical, social, and economic environments (Anderson, 2008; Racette, 2009).

> "Visiting is a way of life with an aim to learn, gather, and exchange knowledge as a way to look after ourselves and our relatives" (Gaudet et al, 2022:321).

Honouring Metis women's knowledge, and that of my own mother and grandmothers, centres Métis ways of being directly connected to the knowledge holders and methods that are part of this research.

> "The methods are determined by understanding the nature of our existence, how we come to know, how knowledge is produced and where knowledge comes from" (Absolon, 2022: 29).

I was searching for the wisdom and teaching held in the stories of the matriarchs, in our own understandings of oral health; this was a situated seeking taking place in my connection to place as a Métis woman, to *lii taab* and the kitchen tables of women I have always trusted to feed, nurture, guide and teach me (Gaudet and Rancourt, 2024). Kitchen table theory has room for everyone to sit and visit around the table (Gaudet and Rancourt, 2024; Racette, 2022) and like in

the circle teachings I have received, everyone speaks, is heard, and contributes. I was not coming to the inquiry as an outsider, nor did I count myself the expert. We the visitors, all of us, were experts of experience.

I visited with ten Metis women from within my kinship network who live in St. Paul/Cold Lake District 12. Given our lived relationships, I was aware they had all previously attempted to access services related to oral health for themselves or their loved ones. It is common for Indigenous researchers to engage in inquiry from within their own communities given that the deep connections and generative relationships in kinship systems befit the axiological principles of Indigenous research methodology. These women came from various stages of life, all matriarchs with central roles in family and community wellness. There were five seniors aged 63 to 82 as well as five middle aged women aged 44 to 56 years old, some with children or grandchildren still in the home and some caring for aging parents. Although I include the women's ages, it is irrelevant from a kinship perspective given that relational ontology from an Indigenous worldview binds the past, present and future into one. When Métis people visit, we sit with the generations of time past, those present and those yet to come.

4.4 Knowledge Gathering

Our knowledge gathering visits centred around the knowledge holders' experiences of oral health and oral healthcare delivery. The relational nature of visiting conversations is inherently congruent with Indigenous research methodology, honouring the oral traditions that are integral to Indigenous ways of knowing, being and behaving towards one another. Enacting *keeoukaywin* as knowledge gathering, I met with each knowledge holder either in my home, their home or at a place of their choosing for 1 - 2 hours. For each visit, I brought along a gift or alternatively, I invited them out for lunch or supper at a restaurant. Additionally, to honour the

sharing of their knowledge and the trust that they were putting in me and the research process, the four Elders in the group were offered a $250 Visa gift card and the remaining six women each a $50 Visa gift card. All visits were audio recorded and transcribed verbatim, using Otter.ai, which was ongoing throughout the project. Our visits were gentle and loving inquiries centred around their and their family's oral health experiences and beliefs. Given we are all invested in each other's wellbeing, this ethic of care continues long after the research process. Inevitably, as with any great visit, our conversations were not exclusive to the research topic. The kinship relationship I hold with each of these women led to a slowing down and a deep reconnection; we teased, laughed, and found mutual comfort and support through our visits. A conversation guide was on hand to prompt further discussion points when needed that ensured the open-ended conversations exhausted the inquiry (Appendix A).

The research visits did not end there. I spent hours reviewing the transcripts from these initial visits, for accuracy certainly, but to also spend time with each of the women again, through our recorded conversations and shared story. With our voices playing through my headphones, I spent many evenings laughing and loving each of them, all the while sitting in front of my computer and letting the learning seep into my soul. Running into one of the ladies at a Métis gathering, I hugged her and said I had just been visiting with her the night before. The way of visiting does not end when we leave one another's physical presence. She laughed knowingly then jokingly responded that she hoped she had been behaving if that was the case.

4.5 Meaning Making

Collaborative Storying

Russell Bishop, an Indigenous New Zealander, and scholar focusing on narrative kaupapa Maori research, has been contributing to collaborative storying as an analytical method since the

latter part of the 1990s. His work is influenced by earlier narrative inquiry theorists like Connelly and Clandinin (1990), Lather (1991) and Tripp (1983). Bishop is critical of the incongruity and power imbalance inherent in thematic analysis in studies involving Indigenous people. He contends that the writing of research results based on outside researcher driven codes and themes is imposing, potentially inaccurate, and can seriously hamper the veracity of analysis and results. True collaboration, from Bishop's perspective, is connected engagement beyond 'polite consideration' of participant opinion. Further, he asserts that what is important in collaborative storying in Indigenous contexts

> "is that it necessarily will take place within the cultural worldview and discursive practices within which the research participants function, make sense of their lives and understand their experiences" (Bishop, 2020:89).

Each of the women in this project were known to me and I to them. Additionally, each of them knew one another, albeit for some, not as closely as I knew them. Regardless, each woman deeply understood and trusted the mutuality and accountability we held for our visiting spaces, for kinship, community and for our Nation.

> "Building on pre-existing relationships of trust is ideal for meaningful Indigenous health research" (Poirier et al, 2022:355)

The weight of responsibility to my community was not taken lightly nor was any work done without the understanding of the group. From the onset, at each of the initial ten visits with the ladies, I reviewed the ethics consent form and the intent to enact visiting as oral health research. More importantly even, I shared that I was committed to not betraying, misconstruing, or misinterpreting their stories and spoke of my mom's earlier experience with research betrayal. They all expressed their trust in me and looked forward to visiting as a group, reviewing together

what had been heard in the initial visits, building on one another's stories, and synthesizing the collaborative meaning of all our knowledge bundles. Over the course of the full day's workshop, the intentional yet intuitive flow of visiting (Gaudet et al., 2020) enacted a collaborative storying process of meaning making that was as natural and known to me as my grandmother, aunt, and mother's ways of braiding rugs.

Rug Braiding as Collaborative Storying

I have come to know, through this research journey, the countless ways that a braided rug reflects Métis women's form and inherent way of research. The crafting of a braided rug is systematic in process and intent. There is purposeful strength and creative genius in well-made braided rugs. My grandmother, and her two oldest daughters after her, are pattern thinkers. My grandmother saw the world in hues of colour and gradients of texture, ways of knowing that she forwarded to her girls. She spent hours sifting through used clothes and bed sheets, she evaluated materials for their durability, colorfastness, and tensile strength. Chosen materials were stripped, organized, and grouped in piles. The braids in a rug varied in complexity, 3, 4, 6, 8 and 12 strands, which when sewn together created a cacophony of color and design. Seemingly discordant up close, once laid out, braided rugs belie mere artistry and demonstrate in their aesthetic a deep understanding of relationship and connection. Always considering her costs and the trends of her potential market she was ever on the hunt for raw materials while never wavering in the quality or integrity of her craft. Her logic was intuitive and generative. Her work was sought after and has stood the test of time; many of her rugs are still found in homes across the Lakeland area today.

My grandmother was renowned for her braided rugs. With eleven children to feed and my grandfather away a lot, she braided and sold rugs to put food on the table (See Figure 4.1).

The artistic labors of Métis women in those times played a crucial role in bringing stability to family economies and impacted the economic survival of communities where Métis people worked to hold onto their homes and land (Troupe, 2023; Racette, 2009). Given braided rug making is so prevalent even today in Métis women's artistic labours which supports our family systems economically and socially, this method both symbolically and practically aligns with *keeoukaywin*. Braided rugs, among many other culturally connected artistic labours like sewing, embroidery, hooked rugs, and beading, are ways that women provide for their family in forms that support wellness, pass on values, traditions and teachings as well as provide resources for the basic needs of living.

Figure 4.1 Millie Lacombe, catching a ride to St. Paul, with her sister Charlotte, brother-in-law, Emile Therien and niece, Dolores, to sell one of her rugs carried under her arm - circa 1968

Rug braiding can be an individual and collective process. Certainly, artisans like my grandmother spent many hours working alone at their tables, stripping materials, braiding, and sewing their patterned creations together. However, this work did not get in the way of a good visit as my grandma also sat with numerous visitors for tea and laughter while she worked. My mother graciously taught rug braiding in a group setting to our regional New Dawn Métis Women's Society. The visits and laughter in this space generated wellness and learning beyond

rug braiding alone. Recently, my mom and I sat together for a few days to braid a rug together and talk about how I could see research praxis embodied in a rug; we laughed and shared moments of deep connection that we would not have had otherwise.

Kinship Rug Braiding

Once the initial visits with each of the ten knowledge holders were completed, I invited the entire group to St. Paul, Alberta, for a gathering to reflect and co-create meaning as a collective. All the women attended, including the adult daughter of one of the ladies and the Elder who has been walking with me throughout this research journey. We met at the Mannawanis Native Friendship Centre for a full day of research visiting that included opening prayer, a gathering circle, and a workshop of cultural art and medicine teaching in the morning, a shared lunch followed by a two and a half hour sharing circle in the afternoon. This space took on even greater meaning for me when I learned that years before, in this very place, my grandmother and my mom's oldest sister, would share their knowledge and expertise in making braided rugs. This folding of time poignantly serves as a tangible reminder that speaks to ways of knowing that acknowledge the very real presence of kinship visiting across time.

> "I think about visiting as practices that collapse time, ways of being in the present that both remember and imagine otherwise" (Jo Billows in Tuck et al, 2023:146).

As each woman arrived at our group gathering in St. Paul, they received a paper copy of the transcript from their previous, initial visit for review. A couple of the women had previously received email copies of the transcripts but received a hard copy that morning as well. Throughout the morning and after lunch I met with all but three of the women, one on one or in mother/daughter combinations, due to the time constraints in ensuring lunch would be served hot

and the afternoon session would be inquiry exhaustive. These subsequent breakout visits unfolded as dialogic reflections that held space for the knowledge holders to reflect on their own storied experiences and intended meanings of our initial visits. The process was collaborative but not host driven as the women responded, modified, and added to their reflections and feelings about the review.

> "Often, the actual words used at a particular time may not convey the full meaning that the person wanted to express. They may be able, on reflection, to express themselves in a manner that further explains or advances their position and understanding" (Bishop, 2020:82).

These morning sessions were audio recorded and transcribed verbatim using Otter.ai.

Braiding requires being present in a way that is reflective, open, and responsive, feeling the pull and elasticity of the strands between your fingers. As the knowledge holder that had been privy to all the research visits, it fell on me to collate the braids that were emerging as we brought our stories together. Over lunch and once again after the breakout sessions were completed, I reflected on what we had been hearing and summarized the strands of our experiences into four categories of braided stories. After lunch we gathered and visit in a sharing circle to dialogically reflect and build on 1) our attitudes and beliefs about oral health 2) barriers to oral health 3) facilitators to oral health and 4) our vision for oral health and oral healthcare delivery for Métis people. As we, the grandmothers, and aunties, sat together and took turns sharing, we sorted our thoughts and reactions and offered further story, recollection or clarification that further created and enriched our collective perspectives and understanding of our oral health.

CHAPTER 5: BRAIDING A MÉTIS WOMEN'S RUG OF ORAL HEALTH UNDERSTANDING

5.1 Sewing Braided Meaning

While my mother and I each braided sections of the rug her and I made, she sewed it all together. A braided rug is a holistic balance of braided tension, colour, and intersectionality. It is in sewing the braided strands that the patterns come together in a meaningful way and that a rug will hold up over time and offer good "under-standing[3]." Sewn together too tight or loose, the rug will not lay flat or conversely fall apart with wear and washing. To achieve the greatest aesthetic in pattern, consistent quality and durability, this last stage is best completed by the skilled sewing of one artisan. For the rug my mother and I worked on, it fell on her to sew together our braids and complete our rug.

Re-grounding and re-membering to place, family, community, and the principles of Indigenous research methodology was an evolving and ongoing way of being that guided me through a deeply reflexive process of sewing together our braided stories of Métis oral health. This responsibility and honour was a physical, mental and spiritual exercise. The cumulative hours of visiting and revisiting each woman, through the audio recordings and transcripts of our individual and group visits, and my visits with the Elder journeying with me through the project, all ran through my head as I sat down to sew our braided stories together. Looking back, braiding a rug with my mom and being both present to the physicality of it and to the knowledge it imparted was not adjunct but foundational to understanding collaborative storying in a Métis relevant context like rug braiding (See Figure 5.1).

[3] "Under-standing" as meant by the stability of what is underneath you. My mother used to say that good sized feet and supportive shoes gave someone a good under-standing.

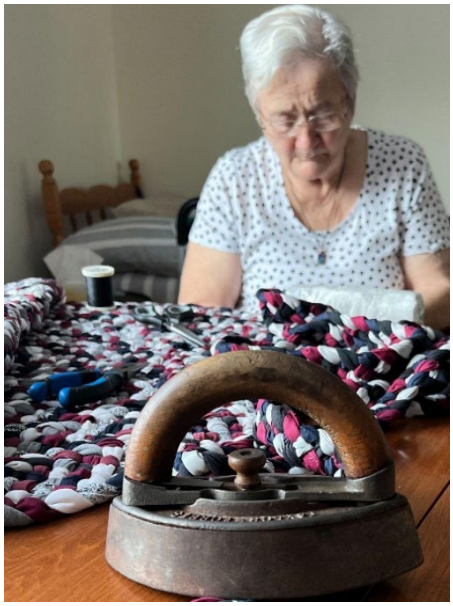

Figure 5.1 My mother, Annette Rondeau, braiding the rug she and I made together as part of this research journey.

I retreated to a sacred space, sought spiritual guidance through prayer, and trusted in the gentle voice within me, of God and the Grandmothers before me. I threaded my needle and looked at the braids in front of me. Throughout our individual and group visits, the women and I had sorted our lived experiences into braided knowledge that reflected our attitudes and beliefs about oral health, uncovered barriers and facilitators to oral health and identified our needs towards visioning better oral health for ourselves, our families, our community, and our Nation. I sat down and began to sew.

5.2 Attitudes and Beliefs

Holistic

The women in our kinship group discussed the importance of oral health to overall health specifically connecting maternal and mental health to oral health. There was a pervasive, holistic understanding of health and wellness braided by the many oral health stories we shared.

"I just think … now that I don't have my teeth, all my teeth, I'm like, I realize how important teeth are… I think they're important for your self-esteem. They're important .... you get more wrinkled if you don't have them. There's so many reasons. If… [you] can't chew food properly, then you don't digest properly. So, it's like teeth are very important" (Knowledge Holder 1- KH1).

Such understanding was demonstrated in stories recognizing that oral health was inextricably linked to mental health.

"I think our mind---the mind body connection is so important in medicine, and I believe it isn't looked at well enough right now….If you're really depressed---the people I've known that were really depressed---do they actually get up and brush their teeth?" (KH1)

"But I ran into a horribly, horribly deep depression, and you don't care about life and the last thing you want to do is brush your teeth. And in that time, I was in that depression for two years...and my teeth rotted out of my head. Right now I'm just starting the process of looking...(indiscernible)...into the dentist. To timing it…" (KH2).

Others added to this braid, connecting overall health and oral health through teachings passed on from our mothers regarding how diet and nutrition impacts teeth, bones and gums.

"*Yeah, my teeth are healthy…and I think it's because … I take my vitamins, right? I take my calcium. Yeah, like I started that… maybe six years now I've been on vitamins pretty frequently"* and *"I learned from my mom. You know, she's always telling me … Oh, my girl, you know, make sure you take care of yourself. Take your vitamins, because I can't drink milk... I'm lactose intolerant"* (KH3)

One of the Elders reflected on how her decision to limit sugar, candy, and pop when her children were growing up was an effort to avoid the pain and infection that could become systemic like she saw in other people's children.

> *"So, I don't know if I did the right thing or not. But I just knew like, I'd see these kids, like God, their teeth were so rotten. And I thought, Oh my God, they must be in a lot of pain. ... and a lot of sicknesses because that poison, I guess, would go through their whole bodies, eh?"* and later, *"And then like to this day, I still take care of my teeth because I seen so many with rotten teeth ... well I didn't know then and I don't think anybody knew it then, but rotten teeth could make your whole system make it ...would poison your system".* (KH4)

Another Elder connected oral health to fertility and conception, providing two examples within her own kinship group where women, who previously were unable or slow to conceive, had born multiple children in short order after having their infected teeth extracted.

> *"but I wonder, and I've heard stories about people---women getting their teeth pulled…this is the second story I know of personally…The woman got her teeth pulled. They were probably all infected or who knows what. And then were able to conceive and carry children" and "another one was my friend …She had these two kids, and nothing happened for years. And then she had her teeth pulled, and I think she had three really quick right after".* (KH5)

Pragmatic

Our stories recounted having to make pragmatic oral health choices for ourselves and our families. Pragmatism sees the world through a lens of results and consequences, lending itself to practicality. Our collective understanding of what constituted a state of oral health fell along a

spectrum of functionality and comfort, whether that included missing teeth or the aesthetics of straight, full smiles.

> *"Oh you'd have a full set…and gleaming…like you look at Hollywood…like you got complete, like you have the money… good for you, like you went and got your teeth done"* (KH6).

> *"I guess, you know, we were very fortunate. They had decent teeth. Had whatever swish in school or whatever they were doing …Plus, on... their dad's side everybody had such good teeth, and Grandma, 93, passed with most of her teeth… And Grandpa, he had...not pretty teeth, but he had his own all his life"* (KH5).

Regardless of how each knowledge holder judged their oral health to be, oral health services were considered expensive and often prohibitive. Our stories presented a pragmatic approach to many of our oral healthcare decisions which were resource limited and pain and symptom driven. Crowns, root canals and orthodontics were considered luxuries, which when pursued, were facilitated through employee dental benefit plans but even then, these treatments were not a given. One knowledge holder pointed out that while work benefits did cover basic dental services, only a percentage of her recommended treatment needs were covered and therefore unaffordable.

> *"When I was 11, I used to be a bad kid…climbing up the side of the house because my dad left his...you know that---what you climb with when you're working? Those sawhorses ...and I fell, and the board flipped up and hit me in the mouth. And I cracked a tooth right here. So in my 40s, one day I was eating, and it broke right off, and that nerve*

was hanging in there. Oh my God. So, I did get into emergency, and they killed the nerve. And they told me I needed a...root canal and a cap. Well, at the time …my job paid for a root canal, but not the cap. So, that lasted about seven years maybe. And then they pulled it out, and they gave me a partial" (KH1)

She also discussed needing additional root canals but not being able to afford the caps:

"So I just told them pull them all out. I didn't even have any rotten teeth…But I just got so I couldn't afford it. I thought what's the point of paying all this money? I could buy a pair of false teeth for the same price. Now… I'm sorry, I did that. But back then I still had kids at home and I didn't have tons of money... I did have some coverage, but not enough to make it worth your while" and *"So, I had three bad teeth. I needed a root canal and a cap on every one, and I could not afford it. So, I just told them, Pull out my teeth… They didn't want to at first but I just said, I'm sure I wanted them [to]. So, I got a plate when I was in my 50s sometime. Mid 50s I think. And I was grateful not to have a toothache"* (KH1).

Another knowledge holder did not consider root canals to be an option for herself or her husband,

"you have to have this pulled or you have to have a root canal … I'm totally against root canals. [I said], you have a choice of either filling it or pulling it. But no [they said], I think you need a root canal. [Again], you can fill it or you can pull it. Take your choice"

and when asked why she felt that way,

"My husband had a root canal done oh well over 40 years ago, and now he has a tooth that's damaged so badly that it's in his bone. And it's, again, still no insurance so nothing has been done about it" (KH7).

Pragmatic choices were a part of the business of living. Especially when people were busy raising children and working to pay their mortgage. As one Elder shared,

> *"Your mouth is just another tool, like your hands and your feet, you know, to do things…And until it affects you...people wanna go" and "Because again, it was a money thing. And so you're always looking at, you know, do I have enough money for this? Well, no. But ..I can afford this, hey*". (KH5).

The women passed on their knowledge and belief about the importance of good brushing and flossing habits to their children, a pragmatic way to prevent dental treatments.

> *"but I was already flossing my teeth because my mom felt it was important and not having benefits at all with four kids. But if we needed to or an emergency or whatever, she would do what she needed to do, right? Or was always taking turns. Alternating between us to go into the dentist. And then she got a job … and so, that was my first dentist experience"* (KH3).

Braiding stories like these together, the women demonstrated that pragmatic decision making regarding professional dental care was not based on financial considerations alone. Although one knowledge holder had benefits, she had been away from professional dental treatments for a time due to other reasons.

> *"It was just like floss, and floss, floss, floss. Brush, brush, brush, consistently and constantly on them. Because again, it's that idea that you can't trust those places or spaces to take care of us. It's, it's not a good space to be in."* (KH8)

"Just took whatever. Tylenol or Advil or...kept it clean. Gargled….and then it kinda passed…And then you go to the dentist, and they give you shit for not...well, you shouldn't do this. I guess I should have...sorry. Sorry!" and "Oops. But it's... just...there's other…stuff that …hurts more, you got to deal with. In your mind, you prioritize" (KH6).

Adaptative

Our stories recounted being adaptive to socioeconomic ups and downs, prioritizing our children to protect them from negative experiences or unmet needs, teaching prevention as we had been taught, relying on choosing providers based on recommendations from those we trusted in our networks. Many Elders in the group added braided oral health attitudes with similarly themed histories that bore a modern-day testament to untreated or maltreated oral disease with little regard for their autonomy. These Elders recounted oral health experiences that we, the younger women in the group, recognized as trauma stories but which the Elders shared as a matter of fact. Stoic in their recounting of negative oral health experiences in the face of limited to no personal agency and systemic barriers, the Elders each chose the only manner of resistance afforded to them at the time; adaptive acceptance.

"I didn't have a good oral, dental kind of experience. Because where I grew up---we grew up without running water. And they used to have a water man. Herb the water man used to bring us 45 gallon drums of water. He'd fill up our barrels every other week or so. But he used Javex in the---to purify the water. And you could smell it…So, I think that impacted our dental health because by the time I was 14, I had to get all my teeth extracted. And dentures, and it was very traumatic because...kids are cruel. And they would harass me. My brother too, he---the one behind me, he lost his teeth early" and "I used to get abscessed, and my face'd be out. Swollen or way far out. Anyway, my mom

took me in, and he said he had to pull a tooth. Of course, it wouldn't freeze because it was abscess[ed], and he actually put his knee on my legs like this, and my mom and my auntie held me down. And he was smoking a cigar while he pulled my tooth" (KH11).

"I can remember [my sister][4] being about three years old before she started sleeping with me. She was basically...had slept in a crib in Mom's room---Mom and Dad's. Or with them. And then, I don't know, at one point ...they made her come sleep with me anyway. Being four or five and having toothaches every night and crying. And either Mom would heat up a little bag of salt, you know, and because we have this one wood burning stove… she just made a little fire and heat this little bag, and you put it on. And it was so nice…Salt, yeah. A little bag. Or else [sister][5]would sleep with me cheek-to-cheek, okay, because the heat, hey"(KH5).

"My granddaughter was born in, in xxx hospital...it was a hot day. I didn't eat or drink anything. And I went from work straight... they pulled her out. And she had this cone on the side. Like they pulled it off of the side of her head. And I seen it. And I thought, Oh my good God, she looked terrible. And I thought---I started feeling dizzy, and I thought, I gotta leave. I gotta get out of here. And so I started walking towards the door, and I fell right on my face. And my son turned me over, and my tooth was sticking out of my bottom lip. And he said, Mom when I turned you over, it scared me more than when I see what...(indiscernible)... [his wife] had coming out. (group laughter) And the doctor told [my son], Okay, you gotta hold her down. Because he said, if I freeze her lip, he said, she's gonna have a bad scar. So he said, I'm just gonna sew her without freezing,

[4] Name removed
[5] Ibid

and it'll heal better. So, [my son] held me down, and the doctor sewed my lip up. And so I had to get this, this bridge. And I must have had it now for about 27, 28 years… I make sure I use dental floss, and I make sure I clean around it good, so it doesn't get any germs and that in there. And I thought, Oh my God, because I sure don't want to have to get false teeth. And in my mind, I still go back to where---I used to see how they, how they had to wear them things. They were horrible for people" (KH4).

"maybe I was 27 or...27, I think, when you're moving here to St. Paul…[the dentist said], you have to go in the hospital and take all your teeth out. So, I went to hospital …my neck was so sore. And then [he] took all 28 my teeth. And then I had to bleed. In the morning, all left, alone until 4o'clock, blood, still bleeding…Nurses, they come and…give me the pan spitting, spitting. A doctor came. He said, "They're still bleeding. And he hollered at [th]em to give him a needle... to stop bleeding. After a while, 6 months, I still didn't have no teeth" (KH10).

"When I look back at it now, I think oh my God, how could that happen? But that's the way it was. But as a child, that first experience I told you, I seen a dentist at 13 it wasn't good. He was like, he basically made me feel like a dirty I don't know what, because they just, well, you're this, you're that, you don't do this, you do that, what's the matter with you? That kind of thing. So really, I really didn't want to go to another one. Probably didn't see another real dentist that time… I think I was 21 or 22. I, my wisdom teeth … they had impacted or what I don't know, I had to have surgery. And I was in agony for how long but then my dad showed up where we were living on the island and gave me the money. And I got them taken out. So that was, I mean, nobody said anything

to me. But it's not always what they say, you know, if you've been treated with prejudice, I mean, you know what prejudice is. So I, it was just normal in my life. That's the way we were treated. But that wasn't, I mean, it was again, it was relief, you know, you don't care. You just want relief" (KH1).

Over the generations and through the labours of our ancestors before who bore the heaviest weights of assimilation and erasure, the colours of adaptive resistance emerged bold and bright.

"So I always tell my kids and they still look after their teeth to this day No. I mean, I think it was just because I was taught that. Right? And my mom always made it very clear, because I can't take you to the dentist. It's just me. You know, and so we need to take care of our teeth. It was as simple, as simple as that, being told that, so that's what we did" and *" I mean, being Metis right. We always had to...people have this idea about us that everything's paid for, like our First Nations people. It's not and that was one of the things that I always had to tell, you know, dentists or health care providers … but the important thing for me was always trying to have a job where I had benefits so I could get my kids, you know their teeth, right. But it was my responsibility too, like because I was a student, there was times I didn't have benefits. And part of my responsibility was always making sure my kids took care of their teeth. So that was like, even like the sugars. That was always important to me, because that's what my mom taught us. Right? Because our teeth are important, right? And we got to take care of their teeth. Brushing your teeth, she took us to the health unit, right? So that they could show us how to floss. How to brush our teeth".* (KH3)

"I don't care, every child, I don't care if you're white or black in between, every child should have access to the dentist at all times. So if they don't have extra money, if they're living below the poverty line, or wherever they can afford it, there should always be something in place, always, in my opinion, no matter what, because that's how it can, you know, decide for himself. And of course, now there's so much like, I always buy extra toothbrushes and have them here for company or for my grandchildren always have a good toothbrush here for when they stay, you know, I always buy the kid toothpaste too.". (KH1)

These mothers sought out jobs with dental coverage, passed on oral homecare habits to their children, accessed public health resources and walked away from oral health services that failed to meet their needs in a safe, trusted manner. More often than not, these were moments of quiet strength.

"But they all knew because we instilled yearly visits to the dentist. We always went and had checkups. We knew whether or not they needed to have any fillings or anything done. And so it made it not the same kind of scenario it was when I was growing up. We--- because of that reason, probably is I pushed for the kids to be able to have regular dental checkups and stuff like that. But it did help because we had insurance. Had we not had insurance, I almost guarantee that it would not have happened" (KH7).

"I had insurance. So I think they always charged a little more. And they really liked people that came with the insurance card because they knew they were going to get more than if somebody come with cash or wanted the cheapest thing done and well, [my son][6],

[6] Name removed

that cost about $500 or $5,000. On top of your insurance" and "Yeah. And a lot of kids never had braces and they'd have this one tooth you know, like some of them had teeth coming out of their gums here and and this tooth was like off to the side and I just felt … that I don't want my kids to have to go through that. I'll pick shit with the chickens as long as I can have you know, a card" (KH4).

" so I spaced out even going to my dentist because it's right here. I'd only go when I had a problem" (KH3)

"because it never felt like a safe space and all it took… was for them to actually communicate and talk to you and" (PD)

"even when I looked into getting braces right? I had to go see this ortho person here, ya know, I can't remember his name …I think he's the one but just kind of rude you know just kind of like I wouldn't be able to afford it anyway but that wasn't the point I was going in there and I was working anyway for the government Yeah, I could have afforded it right" (KH3)

"but he was treating you like you couldn't afford it" (PD)

"because I'm indigenous" (KH3)

"he already decided for you that it wasn't for you" (PD)

"yeah, yeah, and then when I get treated like that I just okay, well, I'm not going to come back here" (KH3).

"So a few years ago, as well, it was kind of like, I had my brother's daughters and they're treaty. And we went to the dentist in [town][7] to get them started and their oral hygiene. We're gonna get the cleanings done and make sure that their teeth were good. And the treatment that we had received was like it was just terrible, like phenomenally bad. And the first thing they wanted was their treaty number they didn't even ask what their names were how old they were, like, you know, just basic human like behaviour it wasn't received well. So I just kind of like okay, we went along with it because I'm thinking well the girls need this. I need to get them through this and we need to figure this out. And when we were talking with the dentist after about the work that they needed, he refused to listen to anything I had to say. They wanted to put gold fillings and caps and I said no, they're yeah like the gold filling, I was like yeah, I'm not into that and it was kind of like you know what, like I'm done. We're done" (KH8).

"I'm like, I know. I'm like, I know what, whatever...you just go back where you came from. I'll just ask not for you next time" and (KH6)

"I'm like, if you're the only one, and I'm like, I'll go find a new dentist, I guess" (KH6).

And later

"Yeah, makes you just go like, okay, like whatever. I'm like, I don't have time to deal with you. I'm like, I'll just go away and maybe not come back. (laughter) Because it's, well, it's in you as, as a woman, right? Like to be respectful. To carry yourself

[7] Name of the town removed

respectfully. So it's like, part of that is just like, not gonna say anything anymore. It's like, bye!" (KH6)

As personal agency increased, adaptive resistance turned into true resistance.

"Not only that, there's huge trust issues to tell the researchers the truth or whatever" (KH1)

"That's you're, you're not going to tell---er, I'm not. I'm just gonna ghost them just like I heard. Like, you just don't look back. You don't tell them that they're awful" (KH9)

(group laughter)"Oh, I fired a few. I got older. I fired a doctor. And I, used to be years ago, I just told them they were full all of it. There was a lady there, a hygienist, that was the cruelest old bag you ever met in your life. You---she's got your mouth full. You can't talk back, and she's like...oh, she's laughing, Would you like a prize? You know? And I said, No, you can shove it. You're horrible at what you do. And I'll never come back here again. And the secretary was like, then she said, "Good for you! Somebody needed to tell her off."(KH1).

For other women, unmet oral health needs further heightened anxieties especially when compounded by memories of their own or their loved ones' experiences of dental service delivery that was not safe due for example to lack of consent or micro aggressive, stereotype treatment.

"I'm sure there was cavities that needed to be dealt with in my front teeth. But I went there for one cavity. That's what I had the money for. And it was the last time I was at a dentist. And he drilled 50,000 holes in my front teeth and filled them, right? Which was fine. And then I went out to the front and you know, even though I had coverage, you

owe 6000 million dollars and it was, I came here for one freaking filling and I lost respect for him after that. And I went to Tim Hortons and I felt so violated" (KH2).

"but I think I might have passed mine [my anxiety] on to her… She's very...she didn't have it in pain, but she had it in the way they treated us. Because her first trip was when I was on social services, and they weren't really nice" and *"I do think I passed that on to her. I mean, she had it the easiest of all my kids. She was the youngest, and you know, she didn't---there's a lot of things they experienced she didn't experience. But just like us, we have that trauma that, you know, like right now you and I are living with grandma's trauma, grandpa's trauma, and the ones before them".* (KH1)

"And my distrust of these people. So I have my guard up already. And that reactivity that we have as traumatized people is something that people need to understand. It's not because we're difficult, it's because we're scared. And it's not because we want to be this way. It's because we've been forced to be like this, we have been put in this situation, time and time again, where we are made to feel like" (KH8).

5.3 Barriers

The distance and time to receive any dental care, resource constraints, lack of dental insurance, type of dental insurance (public or private), copay and out of pocket expenses, intersected with dental anxieties arising from negative dental experiences and/or experiences of discriminatory microaggressions, all of which storied treatment delays and aversions.

Geography

There are 2975 citizens living in St. Paul Cold Lake Métis District 12 of the Otipemisiwak Métis Government in Alberta which spreads west to east from Smoky Lake area to Lloydminster and from north of Wolf Lake bombing range to south as far as but not including Provost, Alberta. The knowledge holders live in rural communities of assorted sizes and with varied amenities available to them. Our stories, once braided together, spoke to the intersecting impacts that rurality has on oral health for Métis people which affects the availability and accessibility of professional and public dental health services as well as the time restraints on scheduling services.

> *"I pretty well staggered them because with the kids---ages are different too. So, the oldest one is 12 years older than the youngest one. So, the oldest one would have been gone before the youngest one was, you know, in school age where he had to do the teeth and stuff when we were doing stuff like that with the kids. So basically, it was only ever the four, but we would make appointments after school. If the kids weren't in school, they went during the day. So sometimes it meant two trips to the dentist during the day. But that was fine when we lived in Wetaskiwin, and you were in town. But when you're out of town, and you have to drive half an hour to get to the dentist, it's an---everybody was in at the same time"* (KH7).

> *"Now there's things, there's programs, at least there was two years ago because I used to fill out the paperwork for parents so they could get the help for their children. And then some of them are not, I'm not in touch with them the way I was two years ago. So I don't know completely everything. And my daughter has good coverage because of her husband's job. But that's not so with all of them. There's still kids who don't get and*

sometimes it's not about coverage. Sometimes it's about parents carrying through and doing what needs to be done" (KH1)

"or even the travel to get into town, eh?" (PD)

"Well that's the way when you have a job. You're an hour to get whichever town you're going to and you know sometimes you, you're not allowed time off. There's a lot of things in the way" (KH1)

"Yeah, it's not so straightforward is just not being able to not wanting to take them or not caring to take them" (PD).

Resource Limitation

Water and food supply were other factors impacting women's oral health experiences.

"So vitamins, like also plays important like calcium. Always think of my teeth and my bones. Because I want my teeth even when I leave this earth Right? I look at people and I, I just learned from them and their dentures. Right. I'm like, I don't want to wear em" and "Yeah. Because my, my cousin, she's younger than I am. She's like 30 or 45?44 45 And she's wearing dentures. But that's the difference. They weren't...Well they grew up, on and off the settlement, but they weren't taught the importance of oral health and the importance of eating vegetables too. But they, they hate vegetables" (KH6)

"Well, if you didn't grow them yourself, though. It's hard. Like if you're not in town, getting fresh vegetables"(PD).

"But also water was a huge issue. We used well water, and I know it's like off reserve or like off, you know, where we were. It's---the water's not good, you have to pack

in and haul in water. So, it wasn't really like a priority to brush your teeth. Because you're wasting water that you could be drinking or cooking with, right?" (KH8)

The business of dentistry and the cost of private dental treatment taxed people's already limited financial resources but also negatively impacted the nature of patient provider trust and relationships.

"I liked that part. I really did. Because again, it was a money thing. And so you're always looking at, you know, do I have enough money for this? Well, no. But I can---I can afford this, hey. … There was no pressure. Whereas, nowadays, I really feel a pressure...I do. And, like, so I had some issues here with a couple of teeth. And so he said---right now I forget what I needed on this one like---but it's going to cost around $3,500, and this one was going to cost about $1,800. I didn't have the money for that because I wasn't working. I didn't have benefits, and my...to do with, you know, old age security and everything. I haven't qualified for the income, guaranteed---guaranteed income supplement, so that...I'm waiting for that to kick in. So, I could go get this work done" and *"Yeah. And you know what I found surprising is no time did they offer me an installment plan to pay for it… And so this, I think, like where I go to is where my grandkids go to and everything, and [my daughter][8] said how good they were, hey. And, and the first dentist I had, who I seen, he was very good. And, you know, not so overbearing as this last of them says, you need this, this, and this, and this is gonna cost this and this is gonna cost that. He wasn't my regular dentist. I got him because I was having pain"* (KH5).

[8] Name removed

"Yeah, and it was a lot easier but like I said still, still if you don't have a couple of $100 on top of 90% coverage in Alberta, you don't have you can't still can't go to the dentist. A $500 visit should have cost me $50. That's it. Not another 500 depending on what it was, you came out of there and you're lucky if it covers 50% sometimes. And if it's so, if it's so close related to heart disease and everything, (whispers) what the #@?"* (KH2).

Financial constraints braided into our collective understanding of Métis oral health barriers. Although dental benefits figured strongly in oral healthcare decision making, not all benefit plans provided equal access. Intersections of affordability, accessibility and acceptability called attention to the structural racism inherent in Canada's private and publicly funded dental benefit system.

"Don't be prejudiced. For one, don't be racist or prejudiced against what insurance you have. People on social services are down and out for a reason. They're not bad people. So you know, like me, I've always worked just having a, had a bad couple of years. Where again, that's another angle you could take as mental health is right in there" (KH2).

"And we don't have millions and billions of dollars just sitting at our disposal in our families. And so, when I think of the dentist, or going to a clinic, or a dental hygienist, I think like it's not safe. It's not made for me. And all they care about is money, or insurance, or if you're treaty or if you're whatever. There's no relationship there" (KH8).

Racism

Magnifying the harm created by systemic racism in professional care spaces was internalized and interpersonal racism from within and without community. This perpetuates personal blame and shame that can feed a cycle of treatment avoidance.

> *"But if you weren't able to do it, after every meal. You did it at least at night so that your teeth were clean, right? And it was always brought to our attention to, as growing up, that you didn't want to have bad breath. And if you didn't, if you didn't brush your teeth, you're gonna have bad breath, and people were gonna think ill of you or something like they would think you were...I don't know how to explain it, but it was like think you were not---not a clean person"* (KH7).

> "*So yeah, like I think that back in the day, we, we were less privileged to have access to any service or even knowledge about dental care. So, when we started having our own children and grandchildren, that changed because I didn't want my kids to experience what I did with losing their teeth at a young age. And it wasn't only the losing teeth. I, I could live with fake teeth, but I had a harder time living with the, the harassment and bullying and stuff like that that went with it. So even today, there's very very few people have ever seen me without my teeth. And when I go for surgery or something, they make you put your teeth in a bowl. Well, the first thing I do when my eyes are open, I..."Give me my teeth!" As I don't like having---I don't like that feeling, and I remember the ignorance of people around me, so first thing I do is I clamour for my teeth"* (KH11).

*"That stigma, and there was a lot of racism. I know that I used to work at the swimming pool when I was doing my practicum for my, my Bachelor of Science: Kinesiology. I suppose part of my learning space, they actually—[an Indigenous][9] school had come. And all of the lifeguards were like, 'Oh God, everybody get your face masks on because the [Indigenous][10] kids are coming.'"*and "*Because it's, like, so important to me that they floss and brush, because it's just built into my brain, I don't know, it's one of the things I focused on maybe because like, I think, too, is that racism part where, like, you're growing up, and it's expected that as Indigenous children, that we would have rotten teeth falling out of our faces, and, you know, because of the fear, but you know, avoiding the dentist is my harm reduction. It really is. Because every time I go, it's an uncomfortable, awkward experience where I don't feel safe. And I leave feeling horrible about myself, and then I don't feel comfortable putting my child in that chair, because are they going to harm my child as well?"* (KH8).

"So anyways, that's where I'm at now. And I mean it's quite humiliating to be 54, trying to get your self-esteem back and you let your teeth fall out of your head and fall apart" (KH2)

Community Disconnect

Our stories spoke to shared concern for the loss of tradition and community cohesion that negatively impacted our ways of teaching and sharing.

[9] Name of the school removed
[10] See footnote above

"Grandpa used to tell me a lot of things. Take the good and leave the bad. You know, you're better off to be happy than sad sort of thing. He kind of had a weird way of doing stuff. He'd tell you stories. He wouldn't put your name in there. But you knew it was about you, because you just had a...when I was jealous one time. You know, I was. He said, "Are you feeling jealous?" I said, "How does jealous feel?" He told me, and I said, "I think so." So, next time I was with him, he told me a story about being jealous and what you do. So, that's what he used to do. So that helped" (KH1)

"Like grandpa Oliver?" (PD)

"Yeah. So, whenever I'm dealing with small children, that's what I try to do. Tell a story. And sometimes I actually put their name in there. So, it's a learning thing" (KH1)

"Yeah, well that's exactly our stories are powerful. That's---you take from everybody takes from the story. That's different learning" (PD)

"I'm so sad right now for that. We're losing that. We're losing visiting. We're losing our stories because everyone's in their phone and in their computer. And they---I so notice that in my grandchildren. And I tell them, "Nope, put your phone away. Sorry. At Grandma's house, you don't get to have that phone when we're eating or we're visiting" (KH1)

"Yeah. Building those connections" (PD).

5.4 Facilitators

Women's Kinship Systems

The strength of our women kinship systems, the intergenerational social exchange of knowledge and nurturing facilitated oral health. The women in our research group related how we and the women before us, played key roles in passing on oral hygiene knowledge and habits,

fostering wellness for our children. The relational, supportive way Métis women's kinship systems transmitted wellness knowledge went beyond a Western understanding of immediate family influence. When Métis women gather, community is strengthened.

> *"I learned more from my, my Aunties and my Kokums that raised me in my community. Because again, I was a free-range child, I didn't really have a home or comfort at one point. So, I was homeless for a very long time at 13. And so I learned more in spaces like this than I ever learned in my own home"* (KH8).

We understood that our role modeling and decision making impacted more than just ourselves and was part of advocacy and responsibility to community wellness.

> *"And then also to me---for me to this day, I get complimented that I don't have that much. I've had some work on my teeth. But to keep doing what I'm doing, right? ...So, I'm gonna go continue going back. I have to go back for a cleaning. That's kind of my story. I think it's---this starts with us as, as women because we were---we're the ones that...it's like saying, men don't really care. But I think it starts with us as nurturers, mothers, grandmothers to, to teach"* (KH3).

Successive generations look to the grandmothers and aunties before them and in turn, this generational wisdom empowers the next generation of women to step into their caregiving and advocacy. One of the women worked in Head Start[11] programming for over 26 and the influence of the Grandmothers was braided into her own personal and professional practice in the community.

[11] Headstart is an Indigenous Service Canada program for preschool readiness and enhancement of childhood development.

"It sounds like you were you, you went above and beyond in terms of advocacy and filling, you mentioned filling out forms" (PD)

"Oh, yeah. Well, that was our job. Right? It was right from day one. It was, I came in when it was a pilot project. So we went all out to help from back then I wasn't a senior. So I, I but I did. I visited pretty well. Most of the seniors here that were safe seniors, visited them and got their input and their help and their advice and it helped a lot. They also were sometimes that's where you went to, you went to granny if Mum, mum and dad weren't carrying through you went to granny and she straightened them out" (KH1).

Public Health Prevention and Promotion

Formative to their own oral health knowledge, many of the women acknowledged and credited the oral health education and promotion initiatives from public health that were part of their school age experiences.

"My mom never had dental care either growing up. Like her parents kind of like...(indiscernible)...in her same way I was raised in a way. But she felt it was really important that we had toothbrushes. So, when I was little she would brush my teeth. I didn't know that so, so that I think maybe something muscle memory there. I don't know. I think prevention was the biggest piece for me because the schools would do this dental program every six months or so. And they would do the toothbrush test to see---or like it was like a little pink pill, and you would chew on it. (indiscernible comments) Yeah, like to show you how well you brushed. And so I kind of took that to heart and took that into my persons. And they would give us toothbrushes. And the opportunity and spaces to

learn. I learned more from parenting groups. So without intervention and prevention programming, I don't think I'd have a mouth. So. Because again, the fear, right?" (KH8).

"And then plus, I remember always with the health care when they would come into the schools. And the fluoride. I used to hate the fluoride" (KH3)

"They make you bite on those trays?" (PD)

"Those trays or you gurgle or I don't know" (KH3)

"I remember a few" (PD)

"Yeah, but do you remember when they used to come in the classroom, I think there was like some kind of little pink pill" (KH3)

"Yeah, I loved those pink pills. I thought they were so cool" (PD)

"Yeah" (KH3)

"Yeah, I loved those. Totally, totally" (PD)

"And then we get a new toothbrush" (KH3).

"I was just gonna say something. It dismays me to know that they're not doing that because that's such powerful preventative care in the, in the schools, like I remember doing that rinse, too. And like, you look in the mirror, it's like, "My teeth look fine," you know. And then you do that, and they're all like pink and gobby. And for me, that---I needed to see that like this is important. My teeth aren't clean. You know, as a kid, like I need to brush them" and "But it really demonstrates to a child, you know, and that's when you want to catch kids" (KH9)

5.5 Needs and Visioning

Women's Cultural Wellness

Understanding our roles as promoters and transmitters of health and wellness in our communities, our stories recognized that supporting and fostering our strengths as a collective would positively impact community wellness, including oral health. Our stories demonstrated that we understood our needs and offered solutions inextricably linked to supporting and strengthening women's cultural wellness. Braided together, our stories empowered our matrilineal strength and tenacity that both celebrated and visioned the continued advancement of oral health and wellness in our communities.

> *"No, no. This is good. My generation and my, my dental history...I look at my kids' dental history...it's improved all the time" and later "... I think without even knowing it, because today was Linda's talk and ... I just thought I am the first generation of my mom's family to be able to be proud to be a Metis woman. You know, like, and now because of me I've got three generations. But yeah, so that's so good. That don't have to live in whatever, I don't know if mom lived in fear, but it just, yeah"* (KH5).

> *"If we could find a program that draws all that teaching together, and the Aunties and the Kokums are teaching you...are teaching the young women. I don't know, like that's so powerful when we all get together" (PD)*

> *"Yeah. Starting in the schools, you know, whatever with what you do, and---how would I say---the parents getting online with it or being okay with it. Supporting it. Then you can move to another step. And then the one step that I keep going back to is the garden with the fresh vegetables. Into promoting healthier eating to...community get together, you know, and just...I don't know, but it could...it just...it could so work" (KH5)*

"Yeah, land-based learning, like gardening...you know, making boulettes[12] with young, the younger generation, like we did it at Bonnyville" (PD)

Relational Oral Healthcare Provision

As a group, we recognized that our decisions surrounding oral healthcare services were deeply rooted in our relational way of being. Together our stories spoke of how loyal and appreciative we were of relational health care providers who really saw healthcare holistically, appreciated and integrated our stories into caring, trusting relationship. One of the women talked about her choice to see the mobile dental hygienist in her community because of the relationship they had.

"She's like, here to help you, you know? So I just started going to her because I just thought she had, really liked the fact that she's so thorough. And I just felt like, I mean, it's not quite fun while you're in the chair, because I don't do the job I should do. So I'm kind of actually relying on her to help me out. And I just think she's ethical. I think we have the same, like we talk a lot about books. I just, just kind of trust that she has my best interest, best of the client at heart. I just trust her. And if I need an actual dentist then she'll tell me. Yeah, it's just nice because there's not a lot of like she's independent. So there's if there if I have to wait it ... because she's busy with the client, she's really good about booking. I don't, I think I might have had to wait once and the whole time I've been going to see her. Whereas if you go to a dental office a lot of times like there's I don't like I actually don't like going to the doctor or the dentist I don't like any of that. Like finances are tremendous. I hate waiting most of the time, the doctor's office in fact, sometimes you have to wait for hours, which is to me disrespectful, my time is valuable"

[12] Traditional Métis meatballs cooked in a bouillon soup

and *"To be honest, though like I kind of like the mobile. Like I prefer it. I actually don't like really the kind of institutional, kind of things where you feel like you're not doing, you know, like you feel judged and stuff like that. So this is more informal and it actually makes me happy."* (KH9)

"And with [your hygienist][13] it's kind of more like a visit" (PD)

"and that she talks sometimes at bad times which I'm sure you're very aware of. Because she'll ask what book I'm reading while she's you know (motions to having her mouth open and not being able to talk) but yeah, it's more, it is more of a visit. It is more of a social occasion and I don't get as stressed out about it as I would going to a big dental clinic you know, and feeling kind of somewhat maybe judged and whatever. So I, I prefer that. And the same actually, like I would like a good doctor but the same like I like that indigenous virtual care because it feels like there's never a judgment to "Oh, you're eating too much junk food" or whatever, you know, like they just deal with my issue" (KH9).

Her daughter also appreciated her dental office because of the care and actions shown by reception staff.

"one thing I like about my dentist, and I've never been on the receiving end of this, but I've been on the other side of it is they'll have people call with like emergency situations. And I've been called a few times and [they] asked me if I can change my appointment so they can fit someone in. And like they always do it very lovely, like nicely, and they always give me a chance to say no, but I always say yes, because I'm like, even if I had a dental emergency, I know that you would go the extra mile to call people and be

[13] Name of her independent dental hygienist removed.

like, do you think you could come at seven instead of eight … you fit people in, and that's happened to me now like two or three times. And I'm like, and it's that receptionist, she goes out of her way to like, fit people in and to make it work for people. And she always acts like maybe I don't know, if she remembers you. She always, like acts like she remembers you and like actually really does" and *"They'll call me and ask me to move and they'll do that for me too"* (KH12).

Women formed loyal, long-standing relationships with oral healthcare providers that they trusted even if these spaces were hours away from their homes.

"Like when I moved to Edmonton, I found this really good dentistry place there in [area of Edmonton][14]. And that's where I go now" (KH3)

"You still go to the same one that you went to in Edmonton?" (PD)

"Because I don't like, like my experience here with the dentist. I don't know. They just, it didn't feel like, uhm, they care. You know,…was just kind of in and kind of out and didn't take their time. And sometimes the fillings felt like not, they felt rough, like they weren't taking, like taken care of … to make it feel like it's a tooth" and *"And so this place that I found in [area of Edmonton][15], … I had to get a couple of fillings. And …he told me everything he was going to do. Like he talked me through it. He's like, hey this is what's going to happen. And I found that it kind of calmed me down. Right? And because I find going to the dentist, sometimes I just get like nervous and I don't know why. But it's just like the thought of having somebody in my mouth. Because my mouth is.. meaningful. Right? And then they were and they're welcoming and… they make you comfortable. And*

[14] Neighborhood name removed
[15] Ibid

… they treat you like a person. And I find here in St. Paul, …. sometimes I didn't really get that. But I mean, we know the history of St. Paul, right. It's kind of sad. Like being Metis I have to go out of my community just to find somewhere where you know, I feel safe" and *"Because for me the important piece is like being in relationship right? Treat me like a human being you know, then I'm gonna be, you know, your number one customer I'm gonna keep coming back"* and "*And for a while, I kind of---you're going to dentist because I find in all things in our life, the relationships with people are very important to me. And so if I found somebody that I just couldn't connect with, or I found that they didn't care, or they wouldn't hear me, I wouldn't go back to them" (KH3)*

Culturally Safe Oral Health Care

Cultural safety, where we felt seen beyond race, income or type of insurance was a common thread in our stories as well. While some women in the group were fortunate to have established trusting and loyal relationships with oral healthcare providers, this was not the case for everyone in the group.

"When we talk about training doctors, training nurses, training dentists, training anyone outside of our, our spaces however, it becomes this buzzword and checkmark. Kind of like first aid training and H2S. It becomes the standardized procedure where they're doing the motions, but they're not really taking in that connection piece. And that heartfelt message that we're trying to achieve when we go into organizations and talk about culture, inclusivity, and that kind of thing. It's really got to be a meaningful, purposeful, committed connection and relationship building because that is like Metis people. We're all about that relationship building. And that's where it gets conflict like conflict happens in those spaces, because they're like, "Well, why don't you have that

extra $3,000 for your pet or? Don't you have 10 grand to fix your f@$% face?" Like, you know, that's the idea. And you're like, "I'm sorry, what?" Like excuse my language, I'm sorry. But it's that … condescending attitude when you walk into those spaces because they were never really made for us. And it was never inclusive to us because it was the privileged that were given those opportunities. Not us. So now that we're coming into these spaces, it's kind of like this gray area still" (KH8).

"It's really important when you find somebody who cares and hears and listens and, and has that compassion enough. "Okay, let's---we don't know the answers now, but we will find them out together" (KH3)

CHAPTER 6: A ROOM TO LAY OUT OUR RUG

6.1 Overview

Métis women in our kinship group believe that oral health is closely related to overall health and wellbeing which echoes the Métis definition of health as reported by the Métis National Council:

> "Health is a state of complete physical, mental, and social wellbeing and not merely the absence of disease or infirmity. It is a state of balance and interconnected relationships between physical, mental, emotional, social, financial/economic, spiritual, environmental, and cultural well-being" (2021:10).

Pragmatic decision making and resourcefulness that reaches for equitable oral healthcare decisions and services prioritize our children's oral health; free from pain and protected from stigma and oppression.

> "Children and families are often thought of as being at the centre of the Métis community" (Graham and Davoren, 2015: 8).

This is rooted in Métis ways of being, knowing and doing to look after ourselves and our collective futures.

> "People felt a responsibility to look after children. Children were regarded as very special because they were everybody's future" (Métis Centre, 2008:61).

While it could be noted that these attributes are also recognized and esteemed attributes of non-Indigenous mothers, asserting our collective knowledge of matriarchal adaption and resiliency in mothering and validating how we prioritize and sacrifice for our children demonstrates a

collective and cultural value system in stark contrast to the colonial deficit narrative that portrays Indigenous people as broken and ill equipped to parent (Muir et al, 2019).

> "As a Nation we honour our Matriarchs, who have love, lost, and fought as many, if not more battles than our men. They were truly the first working mothers, as historically, they were the country wives of men who certainly would have perished without the women's Traditional Knowledge – how to survive in the wilds of Canada and who had far-reaching kinship networks. Later, while the men were hunters, the real work fell onto the women. They would butcher the bison, dry it, and create pemmican for the pemmican trade, not to mention the sewing, beading and embroidery they would do – both for their loved ones, but also for commerce and extra income. As a Nation, we recognize that women are true leaders in our community. Despite racism, oppression, and marginalization, women have always guided our Nation and family units, and continue to do so, including with dental health (Colette Poitras, personal communication, March 6, 2024).

Collectively, our group embraced the important influence of the Grandmothers and Aunties to nurture and ensure the wellness of their families and communities (Gaudet and Rancour, 2024). The women in our research group related how we and the women before us, assumed key roles in passing on oral hygiene knowledge and habits that demonstrated resourceful determination to provide basic dental care to their families in the face of complex systemic and structural barriers to care. A recent study of Aboriginal and Torres Strait Islander parental motivators in childhood oral health had similar findings.

> "Parents in this project were motivated to prioritize preventive oral health behaviours for their children due to worries of poor oral health, embarrassment of children. These motivators stemmed from personal experiences of oral health or observations of family and community oral health, similar to previous research with different Indigenous communities in Australia (Poirier et al, 2021:9).

The vital role Métis women and women's kinship play and have played in both the birth and survival of the Métis Nation and the continued nurturance, guidance, and provision for our families and ergo our Nation, in the face of adversity (Iseke-Barnes, 2009) could arguably be seen as intrinsic and extrinsic, individual, and collective promotive factors, assets and resources of resilience (Njeze, 2020).

Visiting about Métis oral health gave us space to critically examine the societal discourse of blame and shame towards Indigenous people for having unmet oral health needs (Durey et al, 2016). This created the space to look at how an economically driven, deficit focused oral healthcare system in Canada reinforces social stratification of power and agency according to socioeconomic and structural determinants of health (Baker et al, 2023). The politic of private versus public funded dental care, and the tensions of federal and provincial oral health expenditure and investment further entrench oral health inequity in Canada (Quinonez, 2021) and is a history that contributes to the lamented end of public oral health promotion programs that many of the women in our research group benefited from and integrated into their knowledge systems.

Our stories uncovered intergenerational experiences of negative, unsafe dental service provision and trauma, premature tooth loss, poor fitting dentures, rotten teeth, and pain that

ingrained dental anxiety and aversion. This corresponds with what some researchers have referred to as a

> "vicious cycle of dental fear whereby people with high dental fear are more likely to delay treatment, leading to more extensive dental problems and symptomatic visiting patterns which feed back into the maintenance or exacerbation of existing dental fear" (Armfield et al., 2007:1).

Many of the women shared stories of how limited affordability and access to dentists or dental hygienists was related to adaptive, pragmatic attitudes and decision making where treatment was sought mainly for toothaches. Complicating factors like lack of dental insurance, type of dental insurance and the distance and time to receive any dental care added to our aversion of prohibitive costs of treatment.

Our stories demonstrated adaptation and resistance to geographical and resource limitations faced by Métis communities, like financial constraints and food and water security, socioeconomic health determinants reflective of historical and contemporary colonial impacts (Banerji et al, 2023; McDougall, 2017; MNC, 2021b).

Finally, our kinship group visioned a community future of safe oral healthcare spaces, relational oral healthcare providers and reinvestment in Métis relevant and informed supports.

> "Dominant relations of power are challenged 'when community thinks about where they are now, how things come to be that way, and from these starting points how in practice, things might be changed'" (Gaudet, 2014:80 of Kemmis and McTaggert, 2000:573).

This vision echoes the intent and calls to action of the Truth and Reconciliation commission report of 2015 and of current Métis literature (Gmitroski et al, 2023) like, for example, a recent study presenting recommendations made by Métis women, two-spirit, and gender diverse people for improving access to health and social services in Victoria, British Columbia calling for

> "(1) warm and inviting service spaces, (2) Métis-specific cultural safety training, (3) Indigenous specific clinic, (4) wholistic or integrative service delivery, and (5) non-judgmental service providers" (Monchalin et al, 2022:327).

6.2 Discussion

Our co-creative story work highlighted how Métis women's ways of being generated resurgent Indigenous practices of refusal. The women in our kinship group did not pathologize ill health that would leave them immobilized (Dorries and Harjo, 2020). Rather, our desire-based work emphasized the importance of early intervention and prevention knowledge transmission to avoid more severe dental issues down the road. We acknowledged how formative the school based oral public health initiatives and promotion programs of our youth were in developing our own oral health knowledge and we lamented government funding cuts that now limit or relegate intervention services and health promotion initiatives to the sphere of private dental practice for our own children and grandchildren. We believed in and directly benefited from positive role modeling of the generations before and we visioned an improved system that would invest in social and health promotion programs and services to build on cultural, community strengths.

This research braids together Métis women's perspectives on oral health and wellbeing that counters deficit focused, negative descriptions of disparate Indigenous oral health outcomes and resists the stigma of perceived complacency and brokenness of Indigenous people. It does this by voicing, celebrating, and honouring the work and experiential knowledge of Métis

Grandmothers and Aunties that identifies, nurtures, protects, and builds personal, family and community resiliency and resourcefulness. Gathering and visiting with these strong matriarchs in my kinship system, we co-created and generated knowledge surrounding Métis oral health experiences and contributed each to the other's wellness, bolstering our individual and collective sense of self in the process.

Radical sovereignty, as discussed by Indigenous Mvskoke scholar, Laura Harjo, is

> "a type of action and freedom realized in everyday and vernacular spaces against the grain of the politics of settler colonial elimination ... a tool to find our way back to the ways in which community is already performing sovereignty and enacting energy and kinship governed by love for the community" and "it does not have to wait for the nation-state to recognize it or deem it legitimate. Instead, it is embodied in being Mvskoke and practiced without permission from anyone" (2019:39).

'Radically sovereign' aptly describes this community led, IRM framed thesis project, fostered, introduced, and shared with the oral health research community in Canada in a vision for

> "evoking new theoretical discourses of inclusiveness, engaging the once invisible and excluded. It is an exciting time for theorists and scholars, but it is also testing every aspect of the 'tried and true' customs of institutional knowledge centres (Kovach, 2009:156).

Each of us participated in this project as researchers and experiential experts. We identified and sorted our visits into knowledge bundles and undertook a novel, radically sovereign approach to meaning making through the culturally significant art of rug braiding. Radical sovereignty, as aptly described by Harjo (2019) and Ellasante (2021), encouraged and fueled our collective work to forward and reclaim rug braiding as a Métis relevant and novel framework to describe our

collaborative story analysis in this project. Summarizing our oral health attitudes and beliefs, examining the barriers and facilitators impacting the oral health of our communities and visioning change to ensure holistic, safe healthcare and oral health outcomes, we laid out our rug of oral health understanding. Through this generative work, we resisted the historical and contemporary erasure of Métis people as a distinct Indigenous people from an oral health care system that neither yet recognizes, fully understands nor addresses Métis specific contexts, strengths, experiences or needs in commensurate measure.

Braided together in our stories was the undeniable evidence of Métis people's resilient, adaptive, and strong collective identity. Asserting this knowledge is an act of radical sovereignty.

> "The strong attachment a people maintain to their unique cultural identity and the distinctiveness of their particular relationships to these elements also remind a people that their culture is endangered by external assimilative and acculturating forces; that, in the face of settler colonialism, their persistence as a people will require their concerted effort" (Ellasante, 2021:1511).

The experiential knowledge of these advocates, caregivers, and storytellers in relation to healthcare and oral health in our communities demonstrated that Métis matriarchs are not victims. Although they survived victimization, they did not embrace victimhood. Resounding the work of Indigenous scholar, Tricia McGuire Adams, Métis women's lived experiences of negative health outcomes and treatment simultaneously embody determination and the historical and intergenerational trauma of colonialism (McGuire-Adams, 2020). These women would rather 'pick shit with chickens' than see their own children's oral health needs left unmet. Without exception, across the generations, the women in our kinship group found jobs that ensured dental benefits for their families or bolstered their family incomes to afford noninsured

dental treatment. We universally prioritized our children's oral health over our own and we chose oral healthcare professionals for ourselves, and our families based on the recommendations of people we trusted and the relationships we created with culturally safe, relational care providers.

Métis oral health and Métis people are under examined, underreported, and underrepresented in oral health research. The predominant pan-Indigenous approach to oral health research involving Indigenous people perpetuates colonial harms and erasure. The systemic racism and oppression Métis people face have their roots in distinct historical, cultural, socioeconomic, and political contexts that frame our contemporary oral health experiences and outcomes. Counterbalancing the stigma created by deficit focused oral health discourse, our Métis women's kinship group demonstrate community and cultural resilience and resourcefulness in their roles as caregivers, nurturers, and keepers of wellness knowledge.

True to who we are as Métis people, our diverse array of experiential knowledge, once braided and sewn together, revealed a rug of understanding that displayed textured, complex patterns and tensions of intersecting social identities, relational ways of being and doing, and resiliency embodied in adaptive and resistant sovereign acts of taking care of ourselves, our families, and our communities as Métis matriarchs. Our story work voiced the important work of Métis women displaying individual, family, and community resiliency in response to the negative impacts of colonization and erasure. The oral health treatments or lack thereof that they accepted, moved passed or resisted were born of resilience, in response to historical, systemic, and intergenerational forces of erasure.

6.3 Limitations

This research project was limited to women from my kinship network with a shared connection to the homeland of Métis people in the St. Paul-Cold Lake District 12 of the Métis Nation in Alberta. District 12 is only 1 of 22 districts within the Otipemisiwak Métis Government of the Métis Nation in Alberta. The Métis Nation is a distinct Indigenous People in the country we call Canada but also a vastly diverse people. In this project, we recognize that we do not speak for Métis women everywhere. What we share comes from the rich histories and knowledges of our ancestors before us and is not meant to be a representation of all Métis communities. The time and resource limitations of a master's research project meant limiting the number of knowledge holders and visits that could be included.

CHAPTER 7: REFLECTING ON THE JOURNEY

7.1 Reflecting on Indigenous Oral Health Research and IRM

The responsibility, reciprocity, respect, and relevance inherent in the application of Indigenous research methodology in health research creates relational, culturally appropriate inquiry spaces. Here, researchers and community members build stronger relationships and safely explore how the legacy of colonization, cultural erasure, assimilation, adaptation, racism, and victim blaming contributes to the inequality surrounding Indigenous oral health. Through a culturally secure Indigenous research methodology like keeoukaywin, the oral health community can gain appreciation for Métis culture and a deeper understanding of their experiences and perceptions of oral health and oral healthcare. This in turn can inform culturally appropriate and safe oral healthcare delivery for Indigenous peoples. Indigenous research methodology, grounded in culture specific traditions, customs, and community priorities. This can lead to strength based, relevant and equitable development of self-determined health promotion policy and programming.

Braiding rugs of understanding in research creates opportunities for situated knowledge transfer that supports and provides for the tangible and intangible needs of the community. The strands of people's stories have their meaning in relationship; knowledge is held and carried in collaboratively braiding these strands together through visiting as each person gives and connects their stories to those of other visitors. Sorted and sewn together, strands into braids and braids into rugs, like Pedri's presentation of Anishinabe methodology where the drum holds the meaning of their songs and stories, the braided rug "is our document" (2016:394). By braiding our stories together, co crafted with purpose and intent, the rug becomes an embodiment of

observed connection, trends, and relational forces in our stories; it is the understanding and results that research inquiries seek.

"While working with the data using Indigenous modalities, the patterns you perceive through cultural practice and ancestral connection will yield deeper understandings, richer findings and emergent applications for those findings" (Yunkaporta and Moodie, 2021: 92).

7.2 "A reflective end is, in fact, not an end at all"[16]

Traditionally, kitchen-table visits involve the sharing of food (Gaudet 2019). This research journey has given me much food for thought. I do not remember how old I was when I started internalizing the message that there was no time to think. At some point along my path through adulthood, I went from walking the fields of my childhood farm, pondering the angst of puberty and asking, "are you there God? It's me, Paulette"[17] and the next minute, we moved from the farm and I grew into an achievement focused, frenzied task-jumper. Unfortunately, I also sacrificed visiting; my actions bent towards squeezing the most work out of every day. Socializing eventually became limited to impersonal exchanges on social media while clipped text messaging replaced phone calls to my mom or the Aunties. In so doing, I discarded a critical key to my social, cultural, and personal wellbeing that I am, only now, revisiting.

7.3 "Whatever road you go down, you take you"[18]

My mom's words echo in my head. She is a wise woman. She is a wise Elder. While she did not always see herself as the latter, in that one sentence, she unwittingly passes on her intuitive faith in location and positionality. In an era long before Twitter, my mother, and her

[16] Bolton et al, 2023:171

[17] "Are You There God, It's Me, Margaret" a popular young adult 1970 novel by Judy Blume.

[18] I have chosen to use sayings from my grandmother, Millie Lacombe and mother, Annette Rondeau to organize my closing reflections

mother before her, offered much wisdom in 280 characters or less. I find myself repeating many of these sayings to my own children, passing on generation old knowledge often as unconsciously as breathing. It is moments of memory like this that make me so thankful these matriarchs have been a part of my research journey. The space this journey has created for critical reflexivity and introspection has afforded me much needed time to slow down, look twice and contemplate the road behind me, the road I am on and the road before me. Through every article read and every discussion enjoyed, I have remembered, reconnected, and reclaimed pieces of my Métis identity that lay hidden and set aside to the road allowances of my own colonized mind. In doing so, I have recovered vibrant, fluid ways of knowing, being and doing that I did not appreciate before. Through this lens, who I am is being re-colored in an ever-evolving kaleidoscope of becoming. Perhaps this is part of the decolonizing revision and recontextualization of past, present, and future of which Absolon and Willett speak (2015). I am encouraged by Kovach's reminder that Indigenous ways of knowing "are both cerebral and heartfelt" (2005:27). In her experience she said, Elders remind us that "if you have important things to say, speak from the heart" (2005:27). Kovach obviously has a wise grandmother too.

7.4 "We'll get there when we get there"[19]

"Are we there yet"? I used to whine from the back seat of the car on any trip longer than 20 minutes, especially when crushed between two cranky older brothers. Not only would I grow impatient whenever we left our farm and Bonnyville behind, once we passed the curves that signaled we had passed Moose Mountain, the excited anticipation and realization that we were on our way to my grandmother's house made me squirm and annoy my brothers all the more. I

[19] I have chosen to use sayings from my grandmother, Millie Lacombe and mother, Annette Rondeau to organize my closing reflections

could not wait to get to St. Paul. St. Paul meant cousins and visiting. It was playing cards for nickels, Uncle Albert whittling me doll furniture, eating chicken hearts, gizzards, tripe, and duck soup, shopping at Co-op, Hank Snow on the radio, and listening to the adults who stopped by for tea and laughter with my grandma, Millie Lacombe. She drew people to herself, with her memories and tales of a life in which she always found hope and laughter, no matter the struggles. The pilgrimage to Grandma's always dragged on, it felt like you would never get there. Inevitably though, once you got there you never wanted the visit to end. In a way, the path to my thesis defense has also felt like it was too long and winding. Now, I cannot imagine nor want this visit to end.

7.5 "I've always been a kitchen table person"[20]

I was having coffee with mom and reminiscing about my grandma sitting at her big wooden table, braiding away. Secondhand clothes and bedding stripped and piled by color all around her, her tea warm or cold beside her in a mason jar. On all of her walls hung teacups from around the world, gifts from her sons who had served overseas and friends who knew how much she loved to collect them. Yet she drank her Red Rose tea from a quart sealer. My mom was cut from the same cloth. When she went to visit my aunties, they always found themselves at the kitchen table. "Mom did everything at the kitchen table, I guess I have always been a kitchen table person" my own mother said.

Thinking about it now, I realize how drawn I have been to kitchen table people. I know many already: sisters, aunties, cousins, Elders. The more I grow into who I am, the more other kindred kitchen table folks become part of my kinship network. At some point in my second

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semester of graduate work, I heard a student speaker, either in class or on a podcast, share her experience of meeting an Indigenous scholar, in person, for the first time. She shared she had been "crushing on" their work and felt connected to them like they were friends. It is easy to relate to the one-sided deep connectedness established by the writings of some authors. Janice Cindy Gaudet is one such scholar to me. Her work is transparent and personal and what is most brilliant is that her own research journey teaches me something different every time I sit and spend time with her. Cindy is a kitchen table woman and having her walk with me on my own research journey as a committee member has been an honor.

7.6 "When you do a job, do it right the first time"[21]

What I have come to understand is that the choice to pursue this graduate work has never been just my own. The good work I feel compelled to pursue is born from love and connectedness to my family, my community and to the clients I serve in my dental hygiene practice; it is a journey that belongs to all my relations. Guiding the way has been the rich work of Indigenous scholars like those referenced in this work and the voices of my family and community. But the journey is never over and at times it is winding and arduous. Kovach and others like her, have been directing and amplifying the voice inside me to continue down this road and not stop short.

> "Creating room for Indigenous methodologies is not solely about setting forth another research option on the buffet table. It is about acknowledging an Indigenous cultural worldview and identity, which has long been a site of contention in this land" (2009:158).

[21] I have chosen to use wise sayings from my grandmother, Millie Lacombe and mother, Annette Rondeau to organize my closing reflections

This can be contentious, decolonizing work she asserts, in a world that is not 'post' colonial at all.

> "The difficulty arises when research is told to look 'a certain way' and follow the prescribed steps of a particular worldview that are incongruent with the steps or order that would occur in community. Furthermore, cultural sustainability is integral to Indigenous research…Serving community in this way becomes the individual Indigenous researcher's responsibility, whereas sustaining Western culture through research is a highly institutionalized, supported project" (2009:164)

I am glad I read these words early in the three and a half years it has taken me to complete this thesis. Carving space in the academy has had its challenges. Trekking through the fields of academia, seeking knowledge as a novice Métis scholar, I have picked up more burrs[22] than berries at times. Fortunately, along with the writings of Indigenous scholars before me, I have the same community, family, and friends that I am accountable to for incommensurable support. They have buffered my self-doubt and buoyed me with very tangible, collective resilience and strength.

7.7 "Save the pieces!"[23]

I sit with Cindy Gaudet's consideration of

> "methodology as a way of life" (2019:48),

an assertion that points

[22]Burrs are picked up on clothes and shoes commonly growing wild in fields

[23] My grandmother's home was filled with cups and saucers. Every wall, every china cabinet, every space displayed her collection. If she ever heard one fall to the ground and break, she never once got mad at the grandchild responsible for the upset. Instead, you would hear her voice from wherever she was in the house call out, "Save the pieces!"

> "to the important distinction between relationship-building and relationality in research" (Gaudet, 2019:48).

'Relationship building' as used in community based participatory research does not hold the depth of "relational obligation" or "spiritual responsibility" inherent to an Indigenous understanding of relationality (Gaudet, 2019). Our ways of doing that are intrinsic to Indigenous methodology foster ethical living that is at the heart of wahkohtowin and are not exclusive to research. Today, I re-read

> "keeoukaywin holds great promise as it aspires to bring all the pieces back together, and lead us back to what is right; it is a relational obligation, a spiritual responsibility" (Gaudet, 2019:48).

I realize that although it is taking me a while to 'bring all the pieces together' I feel like I am finally moving from my head to my heart, and it is a road I want to travel over and over again.

7.8 "That is a hard row to hoe my girl"[24]

As Indigenous methodologies continue to expand and gain acceptance, rich, contextual insights emerge that are chipping away at the broad, stigmatizing deficit discourse historically surrounding Indigenous health. Oral health research has been slow to join this conversation which is undoubtedly steeped in dentistry's positivist tradition and patriarchal power relations that remain mostly unchallenged. It is little wonder that, relatively speaking, qualitative oral health research has only just begun to enjoy its full potential, and a promising increase of interdisciplinary mixed method projects has begun. On the other hand, Indigenous oral health

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research, fostered through Indigenous methodology in Canada, is nonexistent at this time. In some ways, appropriating visiting as a mere data collection tool in a contemporary community based participatory approach would have been easier, especially for a novice researcher like me. Gaudry points out that as university-based researchers, Indigenous scholars are often caught between relational community responsibility and requirements of the academy (Gaudry 2015). Certainly, as a novice researcher trying to balance the academic expectations of a discipline unfamiliar with the demonstration of Indigenous methodology in community based oral health research, I sometimes doubted the path I had set my community on and worried that I was not equipped to bring us to a meaningful destination. Part of me wanted to start coding our knowledge bundles, *to do real data analysis*[25]. This self-doubt was my own colonized mind participating in an internal argument for and simultaneously against the hegemonic judgments I was not only anticipating from a faceless academy but that I was struggling with myself. Truthfully, I came to see that fostering community led research through Indigenous research methodology and pointing to a culturally relevant framework for collaborative storying with my community was far less daunting than grappling with the self-realization that I needed outsider validation and permission. In doing so, I was saying I needed to validate us.

7.9 Conclusion

It has been an honour to join with these strong matriarchs to voice and vision the oral health of our communities. So much of this journey has been reflexive work, requiring quiet dedicated space to listen, to be present to myself and to all my visitors along the way. In many regards every article ever read, every class, every meditation and every academic and social

[25] These words are italicized to reflect self reproach and incredulity of my own inner dialogue

gathering with my family and my community has seemed more like fun than work; indeed, every connection has been a visit. I am coming to understand that this is because visiting is "culturally organic" (Kovach, 2009) and it is the fertile soil that nurtures and grounds us as Métis people. It is where I am meant to grow as a Michif woman and as an Indigenous researcher. Tomorrow, I will bring my parents coffee and call my Auntie. The work continues.

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APPENDIX A

Conversation Guide Questions

1. How would you describe really good teeth or oral health?
    - What are some things that you consider to be signs of good oral health?
    - What are some indications that a person has poorer oral health?

2. How would you describe the health of your teeth, gums and mouth right now?
    - How do your teeth, gums and mouth compare to how you talked about good oral health?
    - What dental concerns, if any, do you think you currently have or have had in the past?
    - What do you think has influenced your oral health?

3. What are some of the reasons you would go to see a dental professional?
    - Describe your experiences calling and scheduling dental appointments?
    - How do you pay for the dental services you received?
    - How would you describe your visits to see a dental health professional?
    - How did you feel about the care you received?

4. Tell me about your most recent experience going to a dentist, dental hygienist, or other health care professional for your teeth.
    - When was this visit?
    - What was the reason for this visit?
    - How did you choose the office or health care professional that treated you?
    - What would you like a dental professional to know that could make your experiences better when getting dental care?

5. How would you describe your children or loved one's teeth and mouth?
    - What dental concerns, if any, do they currently have or have had in the past?

6. What are some of the reasons you would seek dental care for your children or loved ones?
    - How do you pay for the dental services your children or loved ones receive?
    - Describe your experiences calling and scheduling dental appointments for your children or loved ones.
    - How did you feel about the care they received?
    - How did you choose the office or health care professional they saw?
    - What problems have you had seeking dental care for your children or loved ones?
    - What are some ways it would be easier for you to get dental care for yourself or your family?

7. Please feel free to share any stories you have surrounding oral health or getting oral health treatment for yourself or your family.

APPENDIX B

PARTICIPANT CONSENT FORM

Title of Study: Hidden Smiles: Understanding the Oral Health Experiences of Metis Women in Alberta

Principal Investigator: Ms. Paulette Dahlseide
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Why am I being asked to take part in this research study?

You are being asked to voluntarily participate in this study because you identify as an adult Metis woman living in the Lakeland area of Region 2 within the Metis Nation of Alberta. The oral health of Metis people in Alberta and Metis people's experiences seeking dental care has not been previously researched. Outcomes from this study may provide oral healthcare providers some insight for meeting the oral health needs of Metis people and inform Metis government and federal and provincial government health policies.
This form contains information about the study. Before you read it, a member of the study team will explain the study to you in detail. You are free to ask questions about anything you do not understand. You will be given a copy of this form for your records.

What is the reason for doing the study?

This study will explore how Metis women understand their oral health and the oral health of their families. It also explores Metis women's experiences accessing dental care for themselves and for their families. As traditional caregivers and knowledge keepers of health and well-being within their communities, Metis women offer important information towards understanding these topics. There will be approximately 8 -10 women included in the study.

What will I be asked to do?

To gather the study information, the investigator will interview each participant in person, through a Metis traditional form of visiting. Each visiting session may last 1 -2 hours and will be audio recorded. Additionally, there will be a voluntary final group gathering of all participants to share a meal and review the study findings. This 3 hour group session will be audio and video recorded.

Participants will receive written copies of the transcripts for their review.

To help analyze the information, each participant will be invited to visit with the investigator and discuss their previously recorded sessions. During this visit, the investigator will share their initial understandings of the meaning created across all the participant interviews and the meaning specific to the participant's own recorded interviews. Participants will be invited to contribute to this analysis and provide their thoughts and impressions regarding how their voices are being represented.

How long will I be in this study?

Overall, participation in this study will require 2 – 8 hours of your time. Approximately 2 hours of your time is needed for each study visit and 3-4 hours for the group session. This study will require a minimum of one study visit for the initial interview.

What are the risks and discomforts?

The risks associated with this study are no greater than those that you encounter in everyday life. It is not possible to know all the risks that may happen in a study, but the researchers have taken all reasonable safeguards to minimize any known risks to a study participant.

To minimize any COVID related risks when visiting in person, current Alberta public health guidelines, in place at the time of the visiting, will be followed.

What are the benefits to me?

There may not be any direct benefit to you from participating in this study. However, this study will help researchers learn more about factors that may impact the oral health of Metis people and contribute to the knowledge of how to meet Metis specific oral health needs.

Do I have to take part in the study?

Being in this study is your choice. If you decide to be in the study, you can change your mind and stop being in the study at any time. You are free to ask any questions you may have during the visiting sessions or at any time throughout the study. During the visiting sessions, you do not need to answer any questions that you are not comfortable with.

Should you choose to withdraw from the study, all audio recordings and written transcriptions of your visiting sessions will be destroyed in accordance with University of Alberta policies.

Will I be paid to be in the research?

A 50$ VISA gift card will be provided to individuals who participate in an interview. Community Elders who participate will be provided with a 200$ VISA gift card. Should you withdraw from the study at any time, you will still receive the gift card.

Will my information be kept private?

All records and information will be held confidentially with anonymized data being accessible to the research team. Interviews will be transcribed by an external service provider that will have access to the recorded discussion.

No participant will be identified in the dissemination of findings. The data from this research project will be published and presented at conferences and community gatherings; however, your identity will be kept confidential. Although direct quotations may be reported from the interview, all identifying information will be removed from the report.

Information provided will be stored on a secure, encrypted, password-protected network drive, as per the University of Alberta policy. Information gathered will be kept for a minimum of 5 years. Any paper copies of notes or documents will be kept in a locked cabinet in a locked office area.

Under the Freedom of Information legislation in accordance with the principles of Indigenous research, you are entitled to access this information at any time while it is in storage.

You understand you may be contacted in the future to indicate whether this interview could be included as data for the purpose of further study by the researcher within the next five years.

What if I have questions?

If you have any questions regarding this study, please do not hesitate to contact the principal investigator, Paulette Dahlseide at pdahlsei@ualberta.ca.

The plan for this study has been reviewed by a Research Ethics Board at the University of Alberta. If you have questions about your rights or how research should be conducted, you can contact the Research Ethics Office at reoffice@ualberta.ca. This office is independent of the researchers.

Oral Consent Statement

I have read the Information Sheet and the research study has been explained to me. I have been given the opportunity to ask questions and my questions have been answered. If I have additional questions, I have been told whom to contact. I agree to participate in the research study described above. I will receive a copy of this consent form after I provide oral consent prior to beginning the interview.

_____	_____
Document Oral Consent received and recorded on tape	Date
_____	_____
Name (printed) and Signature of Person Obtaining Oral Consent	Date