Ronte’nikonhrarò:roks A Gathering of Minds: Developing an Indigenous-led Research Partnership to Promote Child and Family Health through Storytelling

A DISSERTATION

Submitted to the School of Graduate Studies and Postdoctoral Affairs, at Queen’s University in conformity with the requirements for the degree of the Doctor of Science Rehabilitation and Health Leadership

by

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Study Abstract

A teaching from Elder Syexwáliya from the Squamish Nation, shares that it is "only together, that our perspectives contribute to the full perspective… in a way a single view does not capture" (Gallagher, 2019). In the study, *Ronte'nikonhrarò:roks A Gathering of Minds: Developing an Indigenous-led Research Partnership to Promote Child and Family Health through Storytelling*, details the process involved in leading the development of a health research partnership that upholds the right to self-determination of Indigenous Nation-based research partners in collaboration with institutional-based research partners. The journey to formalize the research partnership involved long-term relationship-building efforts with Indigenous organizations and Indigenous leaders. As the Principal Researcher, I aimed to represent Indigenous Knowledge and research practices alongside the Indigenous Nation and/or organization through partnership with Queen's University. The focus of the study was to better understand Indigenous child and family health experiences. The research process was guided by an Indigenous Research Paradigm (IRP). The IRP was informed by Indigenous traditional Knowledge and research practices. The research study was guided by Indigenous community members of the partnering First Nation, known as the Community Advisory Circle (CAC). The IRP was further refined by CAC, to represent traditional healing principles, and community-led research protocols. The study's IRP engages the practice of Indigenous Storytelling methods (data collection) and the meaning-making process involved in Storytelling methods - the Storywork (analyses). Overall, the IRP creates space for Indigenous Peoples to share their Knowledges from their own Worldviews and upholds the Indigenous right to self-determination by promoting traditional healing methods of Storytelling and Storywork. The research activities were facilitated through collaboration between the CAC and I by conducting community-based Storytelling circles with

parents/guardians in the First Nation. The parents/guardians regularly accessed the community's early years programming for children and families. The CAC and I hosted in-person, sharing circles where the participating storytellers could gather in a culturally significant space – the local Cultural Healing Centre at Wáhta' Mohawk Territory. The Storytelling practice enabled the storytellers to share their own meanings of their lived experiences and depictions of unique historical contexts, that shape their contemporary health perspectives to inform the health and educational priorities in the First Nation. The stories were iteratively analysed through collaborative Storywork processes, conducted in person at the sharing circles and member-checked for trustworthiness and credibility through virtual correspondence with the storytellers (participants). The Storytelling analyses informed the collective recommendations and additional health and educational research priorities for the community. Overall, I describe my experience in navigating the development of an Indigenous Nation-based research study, within a Western-health science research degree program, and report the community recommendations mobilized from the Storywork.

Co-Authorship Statement

This work is coauthored by the following members of the Academic Advisory Committee:

- **DSc RHL Candidate:** Karhinéhtha'/Cortney Clark (Queen's University, School of Rehabilitation Therapy[1]; Canadian Medical Association[2])
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- **Committee Member:** Dr. Lucie Lévesque (Queen's University, School of Kinesiology and Health Studies[6])
- **Committee Member:** Kanonhsyonne Janice Hill (Queen's University, Office of Indigenous Initiatives[7]; Retired, 2024)
- **Committee Member:** Dr. Mala Joneja (Queen's University, Department of Medicine & School of Medicine[8]; Kingston Health Sciences Centre[9])

Each coauthor contributed expertise and guidance in their respective fields, supporting the research and development of this project.

Table of Contents

List of Tables

List of Figures

List of Abbreviations

AGM - Annual General Assembly

CAC - Community Advisory Circle

CHC - Cultural Healing Centre

DSc RHL - Doctor of Science in Rehabilitation and Health Leadership

HSREB - Health Sciences Research Ethics Board

ICCO – Indigenous Community Controlled Organization

IKT - Indigenous Knowledge Translation

IRP - Indigenous Research Paradigm

IRS – Indigenous Residential School

MOU - Memorandum of Understanding

OCAP® - Ownership, Control, Access, and Possession

TOR - Terms of Reference

Terminology

Allyship: an ongoing practice to re-evaluate personal privilege and power, based on one's positionality, and seeking to operate based on aligning in solidarity with marginalized groups (Nixon, 2019).

Colonization: A systematic process of dispossession and control over Indigenous lands, resources, and Knowledge systems. Colonization imposes foreign frameworks and erodes Indigenous self-determination, reshaping cultural identities, traditions, and societal structures to serve colonial interests. Colonization is not just historical but ongoing, with present-day impacts that continue to affect Indigenous communities globally (Smith, 2012).

Cultural Safety: is embracing the life-long practice of self-reflection to advance therapeutic encounters with First Nations, Inuit, Métis peoples. Self-reflection is underpinned by an understanding of social space and power differentials. It is the person on receiving care/service who defines what 'safe service' means to them (Balbale et al., 2015).

Indigenous Peoples: The usage of the term Indigenous Peoples refers to the First Nation, Métis, and Inuit in Canada. The shift in language from the term Aboriginal to Indigenous, reflects the preferred term by Indigenous Peoples. However, Aboriginal is still acceptable in many spaces and places. Indigenous also refers to the original inhabitants and stewards of the environment, across Turtle Island (Queen's University, 2024A).

Anti-Indigenous Racism: Anti-Indigenous racism refers to the systemic and structural practices that disadvantage Indigenous peoples, often denying them their rights to cultural expression, health, and self-determination (Allan & Smylie, 2015). Anti-Indigenous racism is woven into public policies, healthcare, and education systems, manifesting as both overt discrimination and

implicit biases that undermine Indigenous autonomy and self-determination (Allan & Smylie, 2015).

Self-Determination/Self-governance: the most important determinant of health among Indigenous peoples and influences all other determinants including education, housing, safety, and health opportunities. Self-determination and self-governance cannot be achieved without grounding in Traditional Knowledge and Ways of Being, which links culture, language, and worldview to health and well-being (Loppie & Wien, 2009).

Social determinants of health: factors that influence a wide range of health vulnerabilities and capacities, health behaviours and health management. Individuals, communities, and Nations that experience inequalities in the social determinants of health not only carry an additional burden of health problems, but they are often restricted from access to resources that might ameliorate problems, which compounds issues (Loppie & Wien, 2009).

Social determinants of health categories:

Distal (e.g. historic, political, social and economic contexts),

Intermediate (e.g. community infrastructure, resources, systems and capacities),

Proximal (e.g. health behaviours, physical and social environment) (Loppie & Wien, 2009)

Violence: the use of force or power, threatened or actual, against oneself, another person, or against a group or community, that either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment, or deprivation (World Health Organization, 2022).

Storytelling: Storytelling in as an Indigenous research method is foundational to transmitting knowledge, values, history, and cultural practices (Kovach, 2009). Storytelling functions as a research method and as a means of preserving and sharing collective memory, with each story reflecting broader cultural teachings and values (Kovach, 2009). This method is often rooted in

oral traditions and emphasizes relationality and community engagement, and respect for the interconnectedness of life (Wilson, 2008). Storytelling allows Indigenous scholars to prioritize Indigenous Worldviews, making it an authentic mode of knowledge creation that aligns with Indigenous epistemologies, which are relational, experiential, and often nonlinear (Wilson, 2008).

Storywork*:* analysing stories to make sense of people's lived experience, to interpret events, and to understand connections between contexts, for example between people, place, land, and language. The principles of holism, interrelatedness, and synergy facilitate pedagogical processes of working with Indigenous stories to create and stimulate meaning-making with the stories in collaboration with the storytellers (Archibald, 2008).

Sustainable transformation: refers to the need for long-term, systemic change that is rooted in upholding the right to self-determination of Indigenous Peoples (Spee, McMurray, & McMillan, 2021). To create educational environments that not only acknowledge but actively support Indigenous Peoples in thought-leadership roles, to integrate diverse Knowledge systems, and initiatives that reflect community-driven priorities. Sustainable transformation requires institutions to commit to fostering inclusive, culturally responsive programming that shares decision-making power with Indigenous communities to shape and lead educational initiatives, ensuring that changes are meaningful, lasting, and aligned with the values and rights of Indigenous Peoples.

Reconciliation: According to the Truth and Reconciliation Commission of Canada (TRC, 2015), reconciliation in Canada means “establishing and maintaining a mutually respectful relationship” between Indigenous Peoples and non-Indigenous settler Canadians. This requires not only acknowledging historical wrongs, such as those committed through colonization and detrimental

patterns of violation, but also committing to systemic changes to support Indigenous rights and sovereignty (TRC, 2015). Reconciliation is thus both a process and an outcome, where structural, legal, and social shifts are needed to foster genuine healing and equitable relations (TRC, 2015).

Dissertation Organization

The dissertation format conforms with the Queen's University School of Graduate Studies and Post-doctoral Affairs guidelines for the Doctor of Science in Rehabilitation and Health Leadership (DSc RHL) degree program. The dissertation is sectioned into chapters that detail the fundamental knowledge required to lead a research study partnership centred on Indigenous child and family health, between a First Nation and a western institution - the University.

Chapter 1 introduces the context, and the people involved in the study, including a positionality statement as the Principal Investigator, followed by descriptions of the First Nation-based partners and Queen's University research partners. The partners include Wáhta' Mohawks leadership and the Queen's institutional-based research partners, including myself and my academic advisory committee. My principal investigator reflection, in relation to being a member of Wáhta' Mohawks and a doctoral candidate at Queen's University is included.

Chapter 2 presents the study acknowledgments, including the Doctoral Academic Committee partners affiliated with my doctoral research at Queen's University, and Indigenous mentors I have been grateful to learn from. This chapter concludes with an important funding acknowledgment that made the conduct of the research possible.

Chapter 3 presents the Historical, Political, and Social Foundations of Indigenous Relations with Canada, that offers an analysis to better understand the value of research partnerships to revitalize Indigenous child and family health through Nation-based Knowledge Systems and healing practices.

Chapter 4, *Leading the Development of an Indigenous Health Research Partnership: Revitalizing Indigenous Knowledge Systems*, is a manuscript that describes Indigenous-led approaches to research in relation to western, non-Indigenous research, and provides an overview of Indigenous health foundations. It is maintained that health sciences research is often rooted in Eurocentric knowledge and social systems and fails to uphold the right to self-determination for Indigenous Peoples through reflecting respectful research relationships. This section provides a recount of how to lead the development of a research partnership amongst Indigenous Nation research partners, and non-Indigenous educational institutions, and is underscored by preserving the Indigenous-right to self-determination. As evidenced by Queen's University's colonial origins, the institution emphasizes the dominance of Eurocentric norms and standards in academia over all other forms of inquiry (Cupples & Grosfoguel, 2018). The manuscript outlines the principle of fostering reciprocity in research by detailing the process I undertook to relationship-build with prospective research partners, notably First Nations leaders. The phases to negotiate a formal research proposal to collaborate on an Indigenous-led rehabilitation and health leadership study are described. Throughout the manuscript, I recount the engagement methods used to maintain positive relationships with the Indigenous leadership. Overall, through focused and iterative engagement with several respective First Nation governing authorities, I was able to better understand the essential community-based Knowledge foundations, to represent in the research agreement. I learned that progress emerges in accordance with the development of trust. This will help to identify the appropriate research purpose, questions, and overall study process.

Chapter 5, a manuscript titled *Upholding the Right to Self-Determination through an Indigenous Research Paradigm and Storytelling to Advance Child and Family Health in Wáhta'*

Mohawk Territory, presents the operationalization of the study's IRP in collaboration with the CAC that guided the research process, including the Storytelling research procedure and the data analyses process of Storywork. The recommendations emerging from the Storytelling research are also presented in this section, to inform the Cultural Healing Centre's (CHC) Indigenous child and family health programming in Wáhta' Mohawk Territory. The study findings and recommendations are described to boost community-led systems transformation and advance Indigenous child and family health priorities in Wáhta' Mohawk Territory. Chapter 5 highlights the strengths of the CHC's child and family programs, and defines areas for enhancing early years-centred, child and family healing opportunities in the community.

Chapter 6 presents a discussion on Health Leadership and introduces the concepts of solidarity and reconciliation. The chapter highlights the argument that all researchers and health leaders have the responsibility to reflect on the history of Canada's relations with Indigenous Peoples, to understand the inadequate approaches to developing healthy children and families through a non-Indigenous research lens.

Chapter 7 is an Indigenous Knowledge Translation chapter that presents an op-ed titled, *(Re)conciling Indigenous Health at Queen's Health Sciences,* to motivate actions to renew momentum in improving the health of Indigenous Peoples within Queen's University's Health Sciences education, training and workplace environment. The piece conveys a story, shared with me of my great grandmother's experience in Canada's Indian Residential School (IRS) system. The information shared in the story, is intended to amplify the voices of Indigenous children and families, that have been subjected to unjust harms. The recount embeds Indigenous lived experiences, through representations of Indigenous Knowledge, into future generations of educational and health systems in Canada. The experience is conveyed to motivate reflection and

reconciliatory action within Queen's University, and all Canadian health education institutions, to enhance partnerships, in authentic support of Indigenous Peoples' rights to determining their own health journeys through research. This chapter is followed by a series of Storywork illustrations that represent the community-based reflections from the Storytelling research. The illustrations were informed by the prominent themes and symbols that were shared in the Storytelling circles and exemplify the child and family health sources and strengths in Wáhta' Mohawk Territory.

Chapter 8 This section discusses the study limitations and proposes future iterations of related research with Wáhta' Mohawks.

Chapter 9 the Conclusion, recounts the overall study features, process and highlights the key recommendations emerging from my experience in the role of building the bridge between the Indigenous community and University processes and Knowledge systems, to maintain a health research partnership.

Chapter 10 presents the study appendices, including the relevant study documents. The formal Research Agreement is included as well as records of Wáhta' Mohawks' cultural healing and community health principles. Formal ethics approvals are included, from Queen's Health Sciences Research Ethics Board and Wáhta' Chief and Council approvals. Further, the study recruitment poster and the research budget are included. A chart detailing the results of the Storywork thematic analyses follows. The dissertation concludes with a comprehensive References list.

1
The Context and People

Positionality Statement– Principal Investigator Personal Reflection

She:kon, greetings, my name is Karhinéhtha', in Mohawk language (Kanien'kéha) which means, *she who leads the trees/forest*, in English. My English name is Cortney Clark and I am a candidate in the Doctor of Science in Rehabilitation and Health Leadership (DSc RHL) program, and the Principal Investigator in this study. I occupy a dual positionality in relation to my Principal Investigator/researcher role at Queen's University and being a member of Wáhta' Mohawks. My dual status as both an outsider, living off Wáhta' Mohawk Territory and formally affiliated with a non-Indigenous university and insider—being an Indigenous woman with Kanien'kéha:ka (Mohawk) family and ancestors shapes the dynamics of my research in profound ways. As a member of Wáhta' Mohawks, I have an intimate understanding of not only my lived experiences, in relation to the cultural, historical, and social contexts in Wáhta' Mohawk Territory, but have pre-existing relationships among the community at Wáhta' Mohawks, including my family members. Although, I did not have pre-existing relationships with the First Nation leadership and study partners, the shared identity, and generational connections, within Wáhta' Mohawks, promoted a sense of relational understanding and unity, that was essential for gathering meaningful data and insights in the Storytelling research. The personal knowledge I have of my family's Mohawk traditions and values enables me to design and implement research methodologies that are culturally sensitive and relevant to the Indigenous Peoples directly involved in the research. I aim to support self-determination throughout the entire research process, through focusing on Indigenous-determined priorities, led by the Indigenous community with my collaboration.

Simultaneously, my affiliation with Queen's University, a Eurocentric university, as well as residing off-Territory, situates me as an outsider. *Eurocentrism*, stems from the term *ethnocentrism* regarded by 19th century sociologist Gumplowicz, defined as "a delusional belief that one's own ethnic group is central and preeminent to any other ethnic group, that has ever existed. (Bizumic, Monaghan, & Priest, 2021). *Eurocentrism*, in relation, refers to European culture, history and social standards, as the basis for judgments concerning the practices of others, with the implication that European standards are superior (Joseph, Reddy & Searle-Chatterjee, 1990). Queen's University can be regarded as an example of a Eurocentric educational institution. The school, Queen's College, was established on October 16, 1841, by a Royal Charter issued by Queen Victoria (Queen's University, 2024B). The document was granted after pressures by the Presbyterians of Upper Canada to establish a college for the education of ministers in the growing colony, and to instruct youth in the Science and Literature (Queen's University, 2024B). The founders modelled the new college (Queen's University) based on the University of Edinburgh and University of Glasgow (Queen's University, 2024B). Queen's University operates predominantly as an example of a westernized university with Eurocentric structures, which is characterized as:

> "a site where learning and the production, acquisition, and dissemination of knowledge are embedded in Eurocentric epistemologies that are posited as objective, disembodied and universal and in which non-Eurocentric knowledges such as Black and Indigenous knowledges are largely ignored, marginalized, or dismissed. The westernized university does not only exist in so-called Western nations." (Cupples & Grosfoguel, 2018).

In 1912, to achieve full university status, Queen's College separated its theological programs, leading to the creation of Queen's Theological College. This separation allowed the

university to expand its academic offerings beyond theology (Queen's University, 2024B). In the 1970s, Queen's Theological College began offering non-confessional undergraduate courses in the academic study of religion, eventually founding a Department of Religious Studies that became affiliated with the Faculty of Arts and Science. Meanwhile, theological education for Christian ministers continued in the Department of Theology, contained wholly within the Theological College (Queen's University, 2024B). As the academic study of religion became the primary focus of Queen's Theological College, it rebranded itself as Queen's School of Religion in 2010. Eventually, the theological programs closed as enrollments became insufficient to maintain a ministerial training program.

The role of Queen's University as a theological college and its implications for Indigenous Peoples is complex and deeply intertwined with the institution's colonial and religious history and evolving academic focus. As Aaron Hughes observes, the creation of Canadian departments of religious studies was often dependent on "idiosyncratic bureaucratic and administrative cultures," which reflects the relationship at Queen's University and the Theological College (Morrow, 2022).

For example, the formation of the United Church of Canada (UCC) in 1925 led to a Christian denomination that placed less emphasis on strict dogmatic conformity, which contributed to a shift that united Congregationalists, Methodists, and Presbyterians (Morrow, 2022). This transformation created an academic environment conducive to more secular, critical approaches to the study of religion, setting the stage for Queen's Theological College to adapt its focus. In the 1970s, Queen's Theological College began offering non-confessional undergraduate courses in religious studies, which eventually led to the establishment of a Department of Religious Studies within the Faculty of Arts and Science, although both Queen's and the

Theological College employed several faculty members to teach across learning environments and disciplines (Morrow, 2022). While theological education for Christian ministers continued within the College, the focus gradually shifted toward academic religious studies. This transition resulted in the rebranding of Queen's Theological College as the Queen's School of Religion in 2010, reflecting the growing prominence of secular academic study over ministerial training. However, as enrollment in ministerial programs declined, the theological programs were eventually phased out by 2012 (Morrow, 2022).

This shift away from theological training for ministers is important when considering the broader implications of Queen's University's historical role on Indigenous Peoples. The legacy of theological institutions, especially in relation to their involvement in colonial projects through continued attempts of assimilation of Indigenous identity, has profound implications for Indigenous Peoples' health within their respective communities. In recognition of its role in this historical context, Queen's University established the Truth and Reconciliation Commission (TRC) Task Force in 2015. The task force's final report, "Yakwanastahentéha Aankenjigemi Extending the Rafters," underscores the need for the university to confront its colonial past and its lasting impact on Indigenous communities. The report includes 25 recommendations for the university to engage in reconciliation efforts and actively address the harm caused by historical and ongoing colonial practices (Queen's University, 2016). These recommendations focus on areas such as curriculum integration, faculty appointments, Indigenous-led research practices, and support services for Indigenous students (Queen's University, 2016). The report emphasizes the importance of building relationships with Indigenous communities, enhancing awareness of Indigenous histories and contemporary issues, and creating culturally validating learning environments, which reflect the spirit of this doctoral research study. By implementing these

recommendations, Queen's University seeks to contribute to the broader reconciliation efforts in Canada and support the well-being and success of Indigenous Peoples within the academic community.

Additionally, a study on Queen's University students titled "Canadian Colonialism, Ignorance and Social Attitudes: A Study of Queen's University Students" reveals the persistence of misinformed attitudes about Indigenous peoples within the student body. The study found that many students hold misconceptions about Indigenous geographies, identities, and histories, highlighting the urgent need for enhanced education on Indigenous perspectives and histories within university curricula. The revealed ignorance by Queen's students reinforces the advocacy aims that focus attention to the outstanding and unresolved violations of land rights, proposed land restitution, and disputes over access to resources for Indigenous Peoples are a major threat to both settler prosperity and self-image (Godlewska et al., 2020). However, these elements are critical to the promotion of self-determination and improving health outcomes with Indigenous communities. These studies further demonstrate the significant and ongoing responsibility of Queen's University, especially in the context of its theological college history, to reconcile with the past and work towards creating more informed, inclusive, and equitable educational spaces with Indigenous Peoples.

Queen's University has a documented history of excluding racialized students that extends beyond Indigenous Peoples. For example, Queen's University endorsed a formal ban on Black students from its medical program, a practice that persisted for over a century and remained in institutional effect from 1918 until 2018, when it was formally repealed (Queen's University, 2020). In 1918, the university's Senate adopted a motion banning Black students from the School of Medicine, effectively pressuring the 15 Black students enrolled at that time to

leave the program and barring future admissions. This exclusion was officially in place until 1965, and the motion remained on the university's books until 2018, when it was formally repealed (Queen's University, 2020). The ban had significant consequences for Black medical students, and representation in medicine in Canada. For instance, Ethelbert Bartholomew, a member of the class of 1918, was forced to leave Queen's due to the ban and was unable to find placement at any other medical school, derailing his medical career. He later worked as a porter for Canadian Pacific Railways and passed away in 1954. In recognition of the injustices faced by Black students, Queen's University posthumously conferred a Doctor of Medicine degree upon Dr. Bartholomew in 2019, which was accepted by his family (Queen's University, 2020).

The university's historical exclusion of Black students from its medical program has been the subject of scholarly examination. Research has highlighted the systemic racism embedded within medical education institutions, including Queen's, and the need for curricular reforms to address these historical injustices. For example, a study published in the Canadian Medical Association Journal discusses the development of an antiracist curriculum at Queen's School of Medicine, using the university's own history as a lens to examine how institutional racism has shaped the medical profession (Boyer & Jackson, 2022). Queen's University's historical and recent issues reveal the long history of exclusion and harm committed to Indigenous Peoples and Black people as illustrated by the systemically rooted prejudices that have dispossessed entire generations of freedoms to pursue safe, self-determining futures through educational opportunities.

The duality of my role as the Indigenous Principal Investigator at Queen's University brings challenges and prospects to the situation that characterizes the exclusionary climate at Queen's. For example, my affiliation with a westernized university with historical and ongoing

marginalization of Indigenous Peoples, and Indigenous Knowledges, may have generated skepticism and distrust from prospective Indigenous research partners. The potential for mistrust was counterbalanced by my attentiveness to power dynamics between my role as an academic researcher and as an Indigenous community member. Specifically, the positivist paradigm that predominates in applied health science research that tends to privilege the conventional scientific ways of thinking, was a barrier to experiential knowledge being equally valued (Green & Johns, 2021). This dynamic required constant reflexivity and sensitivity, on my part, to avoid perpetuating colonial hierarchies, such as adapting to community cycles, readily sharing power and establishing processes to partner with the leadership to uphold the Indigenous right of self-determination. Furthermore, the role required regular, mutual communication and dedicated efforts to bridge the knowledge systems and protocols between institutions and Indigenous Nations. Examples of this in the research process include the formal ethics approvals, and the co-development of the research agreement under Chief and Council's direction.

Overall, I acted as a liaison between the Indigenous research partners and the institution's doctoral program. The role required effective communication and ongoing advocacy for the Indigenous partners' interests within the university. Also, I worked to demystify the Doctor of Science rehabilitation and health leadership applied research program trajectory alongside the Indigenous research partners. As a result of the relationship-building process and throughout the study development, I was challenged to bridge the two contexts. Specifically, by expanding the standard Queen's University health sciences doctoral program model to appreciate the relevance of Indigenous Knowledge systems and health practices, such as Indigenous Storytelling in advancing health. My approach aimed to centre and honour Indigenous epistemologies while holistically addressing child and family-related health priorities. To ensure the study was

grounded in ethical and culturally appropriate research practices, I submitted the research agreement to be reviewed in parallel ethics approvals processes that honored the First Nation's research ethics processes and institutional third-party review. This process involved first engaging with Indigenous leadership at Wáhta', to align the study with Chief and Council's ethics protocols and necessary procedures to secure their approval. After crafting the appropriate Wáhta'-specific research agreement, in collaboration with the First Nation-based identified research partners, I submitted the study for review by the Health Sciences Research Ethics Board (HSREB) to provide third-party review from Queen's University. The institution's ethics review committee acknowledged and endorsed the OCAP® principles—Ownership, Control, Access, and Possession in the ethics review process, by supporting iterative revisions to the study activities and prioritizing Wáhta' community leadership in developing the research agreement and stewarding the Knowledge shared throughout the study. This approach centred the Indigenous research partners in shaping the research design, obtaining community ethics approvals, defining the research environment, and guiding the development of knowledge translation products, ensuring the study remained community-led and culturally responsive. At Queen's University, my study's ethics review process challenged dominant research structures by centering Indigenous voices, agency, and research protocols. The experience of co-leading the creation of a new research partnership, with Indigenous leadership, created a synergistic approach to Knowledge generation and exchange, while informing the standard institutional health research processes. The collaborative nature of the study enriched my relationships, as well as the understanding and representation of my Indigenous Nation's teachings that served to broaden the standard health science research paradigms. In particular, the Indigenous Research Paradigm (IRP) was a conceptual framework co-created and implemented throughout the study

that guided the Storytelling methods, rooted in Indigenous relationship building and community-determined processes. Indigenous Peoples have produced, shared and stewarded Knowledge since time immemorial, and in Indigenous health systems, such as in research, Storytelling is a research method that acknowledges Indigenous oral traditions (Rieger et al., 2020). Storytelling offers the opportunity for community involvement to gather in community-based spaces and to share holistic Knowledge about lived experiences. My role in conducting the Storytelling methods came with the ethical obligation to ensure Indigenous Peoples and their stories are not exploited, among the collective, and the physical, emotional, mental, social, and spiritual components of the stories must be cared for with socio-cultural and personal sensitivity (Rieger et al., 2020). *Storywork,* refers to working with stories to make sense of people's lived experience, to interpret events, and to understand connections between contexts, for example between people, place, land, and language (Archibald, 2008). The principles of holism, interrelatedness, and synergy facilitate pedagogical processes of working with Indigenous stories to create and stimulate meaning-making with the stories in collaboration with the storytellers (Archibald, 2008).

Upon further reflection on my epistemic underpinnings, I acknowledge the foundational concepts I possess towards Wáhta' Mohawk and Haudenosaunee conceptualizations of health and wellbeing, due to my personal identity, holistic health and wellness perspectives, and citizenship within Wáhta' Mohawks First Nation. I recognize that I do not represent all Onkwehonwe (Original Peoples') voices, and I acknowledge the holistic relationship of myself in relation to others and the land (Koleszar-Green, 2016). As an Indigenous researcher affiliated within an academic Eurocentric institution, it is critical to advocate for the Indigenous right to self-determination within the health research space, for the purpose of conducting positive

research partnerships with Indigenous Peoples. Relationship-building efforts were employed through extensive community consultations and the co-development of the IRP - a representation of a holistic knowledge system that informs Indigenous health concepts and is reinforced through culturally relevant approaches. The challenge of being an Indigenous citizen, and a student at Queen's University, presented a unique experience for me as I understood the priority to maintain regular communications and promote understanding between the Indigenous partners and the institution. By holding space for collaborative and emergent dialogue with the Indigenous research partners in the study's entirety, I worked to ensure that the research was beneficial to and met the priorities of Wáhta' Mohawks. Overall, I aimed to conduct research that was respectful, inclusive, and transformative for Indigenous Peoples, by contributing to the decolonization of health and education systems, and in this instance, by revitalizing and restoring Knowledge systems and cultural healing practices in Wáhta' Mohawk Territory.

Wáhta' Mohawks First Nation

Wáhta' Mohawk Territory is a small Mohawk Community located in the Muskoka Region of Central Ontario. The community was established in 1881, when a group of Protestant Mohawks moved from their original home in Oka, Quebec due to religious, civil, and economic differences (Wáhta' Mohawks, 2024). My ancestors were included in this group of families and for the purposes of my doctoral research, returning to my Indigenous community with curiosity, has been cathartic. As generations of family lineage and history have been illuminated throughout the process, the opportunity to contribute to the restoration of Indigenous Knowledge and relationships has been an unparalleled experience.

The research partners include official representatives of Wáhta' Mohawks First Nation including the Wáhta' Chief and Council members. The study would not have been possible

without the expertise of the community residing in Wáhta' Mohawk Territory, including respected community Elders and Knowledge Keepers, who have requested to remain anonymous throughout this dissertation. I extend my deepest appreciation to the Cultural Healing Centre (CHC) leads, the Community Advisory Circle (CAC) who shared their Indigenous Knowledge by way of representation on the study's core steering committee. Through the guidance of the CHC and CAC, the research was relevant to the parents/guardians who were storytellers (also referred to as research partners) that collectively guided the Storytelling circles and engaged in Storywork throughout the collection, analyses, and dissemination phases. The Storytelling circles consisted of a total of seven storytellers/research partners, who requested full anonymity in the study reports. The storytellers spanned adult-aged generations (16 years of age or older at the time of the research study), and collaboratively engaged their identities, Indigenous Knowledges and lived experiences to foster a holistic approach to the Storytelling research, for the collective benefit of child and family health. The Storytelling research restored traditional Knowledge through the relational approach to conducting the Storytelling circles and grounding the relationship-building and Storytelling processes in the language of Wáhta' Mohawk-specific healing principles. The six guiding principles for Community Health and Cultural Healing (Appendix C) characterized the relationships among the storytellers/research partners and I, as the study was developed in partnership with the CHC leads, who are accountable to the principles in the work of the Centre and to its affiliates, such as myself as a researcher. The principles include the following Mohawk concepts: 1) Otanitenrahtsera (compassion for others); 2) Kakwenienstahtshera (respect for everyone); 3) Kanoronhkhwahtshera (love and caring for all); 4) Kahretsaronhtshera (words of encouragement for all); 5) Skén:nen (a state of peace); and 6) Ka'shatstenhsera (inner strength) (Franks, 2021). Each of the concepts were shared

throughout the Centre and are shared with those that engage in regular programming such as with the parents/guardians who attend the early years program. Additionally, I recited the guiding principles to the storytellers orally, in advance of conducting the Storytelling research, when discussing the Storytelling circle protocols. The Elders/Knowledge Keepers at the CHC also contributed to setting the tone for the Storytelling circles to reflect the guiding principles.

As mentioned, the findings of the study are intended to be of direct use to the Indigenous Peoples, therefore the interconnection of the community-based values and the functionality of the CAC has been invaluable to the study's contributions and will continue to sustain child and family health innovations in Wáhta' Mohawk Territory.

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3

Historical, Social and Political Foundations of Indigenous Peoples' Relations with Canada

The following evidence underscores the urgency to consider Indigenous child and family health holistically, as the history and ongoing socio-political structures to separate children from their families, was described as an act of genocide of Indigenous languages and cultural practices that has rendered entire generations with health challenges. In particular, the social determinants of health - distal, intermediate and proximal determinants are critical areas of concern to reconcile Indigenous child and family health (Loppie Reading & Wien, 2008). An Indigenous-led study is one way to promote the Indigenous right to self-determination in efforts to advance child and family health.

Canada's history of governmental relations with First Nations, Métis, and Inuit, have been predominantly characterized by programs with explicitly eugenicist goals, that propagated the assumption that Indigenous Ways of Knowing, Being and Doing were inherently unhealthy (Daschuk, 2019). Therefore, the "unhealthy Indigenous bodies" were controlled by the Federal government to prevent disease transmission to the Settler population. Even when the debilitating forces within Indigenous communities, like the policies of the Federal agents, propagated disease through rotten food, infected clothing, tuberculosis, addiction, as well as government-orchestrated starvation campaigns (Daschuk, 2019). The high degree of medical colonialism, further described throughout this chapter, demonstrates the discriminatory stance of the governmental relations with Indigenous Peoples. Through government-sponsored discriminatory policies, Indigenous Peoples were systemically denied the rights to determine their own life courses and has produced lasting harmful impacts on the health of Indigenous Peoples (TRC,

2015).

Gender and Indigenous Peoples' Lived Experiences

Indigenous feminist scholarship conveys a theoretical framework to uphold the right to self-determination in research, in relation to understanding the Indigenous- woman's relationships with the self, the family, and the natural world (Kuokkanen, 2019). To elaborate, Indigenous feminist theories challenge the colonial gender binary that has instituted patriarchal relations of gender domination as the norm in many Indigenous communities (Kuokkanen, 2019). Today, relations of gendered domination typically characterize contemporary Indigenous political institutions, that have been largely created in the image of western, European parliamentary systems that are characterized by relations of gendered domination (Kuokkanen, 2019). Therefore, my study enlists a counterapproach to Eurocentric gendered structures and systems, that have been defined by Indigenous Peoples as a misuse of power. My study prioritizes establishing research relationships that benefit the Indigenous community, as determined by the Indigenous Nation's leaders and respective partners. The research partnership prioritizes the Indigenous right to self-determination, in particular for Indigenous women, and is a deliberate challenge to oppressive patriarchal structures and systems, that continue to impact Indigenous child and family health in Canada. My Storytelling research centred the voices and authority of women in the community, through the study partnership with the "Mom and Tot Program" (guardian and toddler program). The layered approach to Indigenous community-based leadership in the study, challenged the colonial structures that continue to deny Indigenous Peoples representation and authority, specifically "to the right of self-determination, to the survival of our languages and forms of cultural knowledge, and to our natural resources and systems for living within our environments" (Smith, 2012). Therefore, to promote self-

determination in research, it is integral for researchers to understand the intersectional identities and the diversity of lived experiences represented within Indigenous populations, that are often overpowered by anti-Indigenous, racialized structures and patriarchal politics in Canada. Creating the space for the women in the community to lead the Storytelling research through partnering with the "Mom and Tot Program" inspired change in the ways in which the participating mothers interacted with others and their environments (Kuokkanen, 2019), as well as in this instance, restored traditional decision-making structures within the matrilineal tradition of the Wáhta' Mohawks. Intersectionality is a valuable concept that reflects a broad framework depicting various forms of inequality and discrimination (such as racism, sexism, and classism) and how they intertwine and can compound the other. This concept is instrumental in highlighting the unique experiences of individuals who belong to multiple marginalized groups, thus providing a more nuanced understanding of social justice and advocacy efforts (Crenshaw, 2005). Therefore, when examining Indigenous feminist scholarship, researchers can reflect further on their personal assumptions around identity and cultural norms, to better understand the distinctions regarding Indigenous experiences in Canadian socio-political spheres, to support the revitalization of traditional Indigenous Ways of Knowing, Being and Doing.

The following definition of racism broadens the discussion around intersectional identities represented within populations of Indigenous women and their lived experiences in Canada. *Racism*, a social construct, involves the belief that "one's own race is superior to another and is carried out through discrimination based on policy and outright hatred or intolerance" (Reading, 2013). Racism in Canada, has been systemically reinforced through the inequitable distribution of power, wealth, and resources, that disproportionately and negatively impact Indigenous Peoples' health and wellness, with overt impacts to women and girls. Through patriarchal

constructs sponsored by the dominant society, the widespread racism perpetuates complex barriers for many Indigenous Peoples to achieving good health as evidenced through colonial constructs (i.e.: Indian Residential Schools, the sixties scoop, biomedical experimentation, gendered violence) and carried out through the official systemic structuration that has been founded in anti-Indigenous racist thought (MMIWG Canada, 2019).

Reclaiming Power: The Final Report of the National Inquiry into Missing and Murdered Indigenous Women and Girls (Missing and Murdered Indigenous Women and Girls Canada, 2019), further emphasizes the ways race-based genocide has resulted from ongoing colonialism, racism, sexism, homophobia, and transphobia against Indigenous Peoples. The hate-motivated trends contribute to the staggering rates of violence experienced by Indigenous women, girls and Two Spirit, lesbian, gay, bisexual, transgender, queer, questioning, intersex, and asexual people (MMIWG Canada, 2019). The National Inquiry participants included 2,380 family members, survivors of violence, experts, and Knowledge Keepers, that published appeals for 231 calls to action to improve access to culturally safe and trauma-informed health, social and justice services based on adherence to the rights of Indigenous Peoples (MMIWG Canada, 2019). Decades of Indigenous-informed advocacy has outlined the need to prioritize research projects and related partnerships that augment the representation and resources directed to (re)conciling Indigenous health Knowledge within academic spaces. Thus, health researchers are valuable collaborators to address contemporary health challenges that are disproportionately affecting Indigenous Peoples, including women, families and children.

First Nations Child and Family Services in Canada

In Canada, there are two recent significant legal victories regarding child and family welfare that exemplify Indigenous-led priorities to exercise the right to self-determination to

address child and family health, holistically. For example, in 2023, the class action case which included incidents dating back to 1991, found that there were significant harms, in size and scope, inflicted on the First Nations children and families because of cruel and discriminatory First Nations Child and Family Services in Canada (First Nations Child and Family Services, 2024). The ruling was made with the commitment of $23 billion for the 300,000 children and families who were included in the wrongful discrimination lawsuit, with $20 billion to be allotted to drive system reform over five years (First Nations Child and Family Services, 2024). A review of the crimes included the evidence of an inherently biased system managed wilfully and recklessly, in its conduct, with the systemic incentive to remove Indigenous children from their families, as illustrated by way of the principal and foster-funding models within Child Welfare Services (First Nations Child and Family Services, 2024). Overall, the model for foster-funding received higher amounts of resources, than the principal model, which created an unethical approach to funding individuals who were agreeable to foster Indigenous children, and comparatively less resources were directed to developing preventive approaches to keep First Nations families intact and grow capacity supports within the families and system (First Nations Child and Family Services, 2024). Therefore, the structures and operations of the Child Welfare System in Canada worked to implement further divides and intergenerational harms to Indigenous children and families.

On 9 February 2024, a second precedent-setting decision came from the Supreme Court of Canada in response to Quebec's appeal of the federal government's 2019 legislation, *Act respecting First Nations, Inuit and Métis children, youth and families* (Act). The Act puts forth national standards and provides Indigenous communities with effective control over their children's welfare, affirming Indigenous Peoples right of self-government over child and family

services (Smith, 2024). Quebec had referred the Act to its Court of Appeal, ruling that the law was valid except for two sections- granting Indigenous law equal weight to federal law regarding paramountcy (Smith, 2024). The Supreme Court of Canada then affirmed that the entire law is constitutional pursuant to Section (s.) 91 (24), which expressed the assumption by the federal Crown of the responsibilities formerly held by the British Crown towards "Aboriginal peoples, including welfare and protection provisions" (Smith, 2024). From 1867 to 1982, the utilization of s. 91(24) ultimately depended on the will of Parliament, however in 2019 the decision affirmed that Indigenous-made laws concerning child welfare services prevail over conflicting provincial laws (Smith, 2024). This law sets national standards and enables Indigenous groups or communities to formally enact their own laws within Parliament's authority (as we, Indigenous Peoples, are still wards of the state) under s. 91(24) of the *Constitution Act, 1867* (The Constitution Act, 1867). The Supreme court expressed its aim is to ensure culturally appropriate delivery of child and family services to further reconciliation in Canada. Although no amount of money or policy reform will reverse the harms inflicted to First Nations children and families, the recent case sets the mark that Indigenous Peoples have always had an inherent right to self-sovereignty, right to self-determination and thus, the right to care for their children.

Systemic Medical Colonialism

The Canadian government's policies of racially segregated establishments for Indigenous Peoples were a product of European Settlers making contact with Indigenous Peoples in the land of what is now known as Canada. The colonial powers establishing Canada enacted system-wide anti-Indigenous policies - palpable at all levels of society for Indigenous children and families. For example, systemic medical colonialism was administered through biomedical experimentation in "Indian Hospitals" which evidences the

discriminatory maltreatment to Indigenous children in Canada. *Systemic medical colonialism* is described as a set of ongoing structural processes that legitimates the practice of medicine as a tool for settler-colonial appropriation of land and extraction of resources and reinforces the differential effects of colonization on health and well-being for settlers and those who are colonized (Boodman, 2023). It refers to an instrument of material and political domination, as well as cultural assimilation, that is driven by settler ideology and knowledge-production in educational systems, that "perpetuates the racialized settlement on and of Indigenous bodies through violent forms of cure, care, and disappearance (Boodman, 2023) in Canada's interrelated systems." Therefore, systemic medical colonialism describes the interconnected health dimensions of Indigenous racialization in Canada, through coordinated territorial dispossession and elimination (Toews, 2018).

Systemic medical colonialism in Canada is further exposed by Dr. Ian Mosby's research that details the effects of the "Indian Hospitals'" malnutrition testing practices. Mosby's research exposes the inhumane nutritional studies that were conducted on Indigenous children, within reserves and in residential schools throughout the 1940s and 1950s (Mosby, 2013). One intergenerational survivor remembers her family's experience with Canada's "Indian Hospitals" and the Indian Residential School (IRS) system, "one system fed into the other, but I learned very early in life that it's just one system, one policy - that was to break the child, to break up the family" (Moore, 2017). Canada's "Indian Hospitals," that have yet to be formally accounted for, by the government, provide evidence of systemic medical colonialism in Canada. Ann Hardy, a survivor, reports her experiences of systemic medical colonialism as an Indigenous child, as the representative plaintiff in a $1.1 billion class-action lawsuit filed on behalf of "Indian hospital" child "patients," against the

Federal Government (Pelley, 2018). Hardy asserts that she and other children were "sexually abused and assaulted by the staff, in a toxic environment in which systemic failures enabled physical and sexual abuse to continue unabated" (Pelley, 2018). A lawyer described the treatment at the twenty-nine segregated hospitals across Canada that are listed in the claim as "horrific" (Pelley, 2018).

Amid generations of Eurocentric interferences on Indigenous Peoples Ways of Knowing, Being and Doing, the lasting connections to ancestral Knowledge enabled Indigenous families to remain resilient, and to persevere to reclaim the right to self-determination. Reclamation of the right to self-determination is evidence by the challenge to a policy that led to harmful practice in emergency and critical medical care. This policy was exposed in 2018 by a movement launched by Canadian healthcare providers entitled #aHand2Hold campaign. The campaign confronted the Quebec government's common practice of separating children from their families during medical evacuation airlifts, which disproportionately affects remote and northern Indigenous communities (Shaheen-Hussain, 2020). The #aHand2Hold campaign further exposes the medical establishment's role in the displacement, colonization, and genocide of Indigenous Peoples in Canada, in present day (Shaheen-Hussain, 2020). The evidence demonstrates the existence of the draconian medevac practice of removing children from their homes and families, which is compounded by the province's non-accompaniment policy (Shaheen-Hussain, 2020) The non-accompaniment policy is the identified barrier that has compounded and disregarded crimes and medical violence that legitimizes the practice of removing children from their communities in the north to receive health "care" in the south. The policy has been cited as a standard by the health authorities and has resulted in denying parents/caregivers from access to their child(ren), by way of a parent

accompanying the child to the medical facility. This has resulted in the parents/guardians being left in the community of the airlift evacuation, without information as to the continuity of care of the child. The lack of information provided to parents, and inaccessibility to determine where one's child is being airlifted to, or accompany their child via helicopter, is a common pattern that has devastated Indigenous families, and continues to undermine Indigenous health and well-being. The worst of the experiences and grievances flagged by Indigenous Peoples have been ignored for decades, either by frontline workers or by évaq administrators and government officials (Shaheen-Hussain, 2020). The non-accompaniment policy is in direct conflict with upholding the right to self-determination of Indigenous Peoples, which highlights the importance of training and renewed education to promote positive changes in relationships between health care workers and Indigenous Peoples to advance Indigenous Peoples' health experiences.

In Canada, and internationally, the dominant society's relations with Indigenous Peoples are deeply entrenched in imperialist and colonial structures, as demonstrated by the implications of scientific research, characterized by systemic medical colonialism (Smith, 2012). The ongoing activities of institutionally sponsored medical abuse and experimentations under the purview of bio-medical scientific research resulted in complex harms, traumas, and intergenerational impacts for Indigenous Peoples. The described acts of systemic medical colonialism are collective memories for many of the world's Indigenous Peoples and is a widespread history that still offends the deepest sense of our humanity (Mosby and Swidrovich, 2021; Smith, 2012). Therefore, my study demonstrates a community-centred approach that drives research to enable Indigenous Peoples to share information authentically, and ensures the activities and stories shared, are centred on and directed by the Indigenous individuals and community (Smith, 2012).

The Sixties Scoop ('60s Scoop)

Targeted seizures of Indigenous children, continued amid the Canadian systems, at the control of the Canadian government with the Sixties Scoop beginning in the 1950s (Leybourne, 2024). The reported tragedies were characterized by Indigenous children, again, being taken again from their parents and families, often without consent, in a movement where Canadian governments and its delegates apprehended children and placed them in non-Indigenous homes and as a result, many faced abuses, were stripped of their languages, cultures, and has left generations with complex questions about their identities (Leybourne, 2024). The Canadian government has historically deemed many Indigenous families who were impacted by colonial oppressions and families who were inadequately supported "unsuitable" to care for their children, and the provinces were legislated to utilize child protection services to remove Indigenous children from their families (Leybourne, 2024). Generations of families have been torn apart by the Canadian systems and left generations feeling disconnected and harmed. The increased rates of Indigenous children in the child welfare system, a situation caused by the Canadian government, is an ongoing dimension to understanding Indigenous child and family centred community healing. The individual and collective healing journeys take unique forms but commonly involves the resolution of feelings of grief, through loss of familial connections and cultural understandings. In 2015, Manitoba was the first Canadian province to issue a public apology, with governmental recognition of the existence of the Sixties Scoop, citing an estimated 20,000 – 40, 000 Indigenous children were seized from their homes in the 1960s, 1970s and 1980s and sent as far away as the southern United States and Europe (Manitoba, 2015).

Collectively, Indigenous Peoples have remained resilient to the ongoing challenges posed by colonial interventions, as exemplified by those who survived the Scoop, which was a

contributing force to the epidemic of child apprehension patterns of Indigenous children in Canada. Through the creation of the "Stronger than the Scoop" (the Campaign) Indigenous advocates support adoptees and their families whose lives have been impacted by the child and family injustices (Leybourne, 2024). The awareness campaign acknowledges the role of systemic harms and the intergenerational traumas within Indigenous families and individuals, through commitment to foster healing by strengthening and revitalizing languages as well as cultural connections (Leybourne, 2024). The identified community-specific, and individual-specific healing metrics are important indicators to inform broader reconciliation efforts in advocacy and to advance community-based healing.

The patterns exemplified by the Canadian government, have perpetually excluded Indigenous Knowledges from effectively supporting Indigenous Peoples, by targeting the very existence of Indigenous identities, and by prohibiting the right to determine one's life course including the right to practice culturally embedded protocols and healing ceremonies. The long-term healing journey for many Indigenous Peoples has been confronted by degrees of exploitation and neglect, sponsored by the Canadian government, and has been perpetuated by harmful interventions to Indigenous children and families. Therefore, the Campaign not only serves to improve educational awareness and public consciousness pertaining to the indicators of health in relation to Indigenous Peoples, but also offers an outlet for gathering and collective healing for Indigenous survivors of the Scoop, who engage in the reclamation of their identities and strengths to heal.

The United Nations Declaration of the Rights of Indigenous People

The United Nations Declaration of the Rights of Indigenous Peoples (UNDRIP) is fundamental to understanding the inherent human rights of Indigenous Peoples (2007). The

UNDRIP is an international legal instrument that was adopted by the General Assembly through resolution on 13 September 2007 and describes the individual and collective rights of Indigenous Peoples, internationally. It sets out several principles to guide mutual relationships between Indigenous Peoples and States, including principles such as equality, partnership, good faith, and mutual respect (United Nations (General Assembly), 2007). Canada claims to strongly support the principles, and Indigenous delegates from Canada had been involved in the creation of the Declaration since the 1970s (Hanson, 2009). Despite Canada's presence on the United Nations Human Rights Council, which endorsed the document, and despite the backing of Canadian citizens, legal experts, grassroots organizations and the official opposition party, the Conservative government initially voted against the UNDRIP and refused to sign it. Prime Minister Harper's government did not sign UNDRIP in 2007 due to concerns that provisions like "free, prior, and informed consent" might conflict with Canada's legal framework, potentially giving Indigenous groups veto power over development projects. Additionally, the government feared the declaration could create ambiguity in land claims and disrupt settled agreements, while conflicting with Canadian individual rights under the Charter (Coppes, 2016). After, UNDRIP supporters such as Amnesty International condemned Canada's official position, underscoring that the UNDRIP outlines minimum human rights standards, and complements rather than overrides existing rights (Hanson, 2009). On 12 November 2010, in a manner fully consistent with Canada's Constitution and laws, the Government of Canada formally endorsed the UNDRIP and posits that the articles are consistent, with the Canadian Government's approach to working with Indigenous Peoples (2007). The UNDRIP signifies the global endorsement by 148 countries towards strengthening relations among colonial governments with Indigenous Peoples around the world, by upholding the right of Indigenous self-determination.

The Declaration summarizes the rights of self-government of lands, resources, and peoples, with support through ongoing relationships and negotiations within the Canadian government's jurisdictions (UNDRIP, 2007). The UNDRIP provides guidance to government, organization and policymakers, and sets out "the minimum standards for the survival, dignity and well-being of Indigenous Peoples" to ensure fundamental human rights are protected (Government of Canada, 2023).

In 2016, the Government of Canada endorsed the UNDRIP without qualification and committed to its full and effective implementation. On June 21, 2021, the United Nations Declaration on the Rights of Indigenous Peoples Act (UNDA) received Royal Assent and immediately came into force with the creation of a framework to advance the implementation of the UNDRIP at the federal level (Government of Canada, 2023). With the development of UNDA, Canada's demonstrating a commitment to uphold the right to self-determination of Indigenous Peoples. The UNDA holds significant implications for the health of Indigenous Peoples in Canada by providing policy precedent that upholds the rights to access traditional lands, and the preservation of cultural practices, all of which are deeply intertwined with health outcomes (Government of Canada, 2023). In relation to my research study, the entire process was rooted in the Wáhta' Territory's land-based knowledge, spirituality, and traditional healing practices of Storytelling. This decolonial process promotes the official recognition and integration of Indigenous Knowledge systems into public health research frameworks. As a result, the integration of culturally relevant, community-led, and rights-based approaches to research partnerships enhances Indigenous Peoples' ability to revitalize and sustain Indigenous child and family health.

The Truth and Reconciliation Commission of Canada

Indigenous Peoples' lived experiences in Canada have been uncovered in the work published by the Truth and Reconciliation Commission of Canada (TRC, 2015). The Commission embarked on a national campaign, to document the experiences of survivors of Canada's residential schools and to increase awareness among the broader public to support healing for the generations of families affected by the IRS system. The Commission's Final Report addresses how Indigenous Peoples have been systematically denied the right to determine their life course and have been subject to colonising and assimilatory strategies targeting Indigenous Peoples to "cease to exist as distinct legal, social, cultural, religious, and racial entities in Canada" (TRC, 2015). The TRC Final Report estimates at least 150,000 Indigenous students attended 139 government-sponsored, church-run, residential schools, and residences, from 1831 to 1997, where students endured, in many cases, lethal forms of physical, emotional, mental, spiritual, and sexual abuse (TRC, 2015). The survivors of the residential schools faced traumatizing experiences while in the school system, and those that returned home to their communities as young adults, often struggled to parent after being separated from their families and traditional cultures (TRC, 2015). It has been widely recorded that the oppressive colonial policies and structures upheld within the residential schools, have resulted in widespread intergenerational traumas and unresolved grief in various forms for Indigenous Peoples today (Dennis & Minor, 2019). The 94 Calls to Action in the TRC Final Report represent a population-specific response to advance reconciliation in Canada, with the aim to address the multitude of system-wide inequities, as it applies to Indigenous populations (TRC, 2015). Health sciences academic institutions have a responsibility to respond to the Calls to Action. Health and education reforms are emerging priorities for institutions, however low to moderate progress has been made in the health and education Calls to Action, as reported by the annual TRC Report

Card in achieving the Calls to Action in the Truth and Reconciliation Final report (Assembly of First Nations, 2023).

To review, the Final Report details 94 Calls to Action to create more equitable systems in Canada, rooted in decolonizing the ontological foundations that dictate institutional processes, inclusive of health research, educational, legal as well as child and family realms (TRC, 2015). The Calls to Action items 1-42 are dependent on structural reformation to systems, through promotion of the Indigenous right to self-determination in Canada, and 43 - 94 centre on national reconciliation recommendations. The health-related Calls to Action 18 - 24 are aligned with the overarching objectives of my study, as the Calls to Action address the interconnected and multigenerational impacts Canada's policies, including the Indian Act and Residential Schools, has had, and continues to have, on Indigenous individuals and communities. Further, the Commission calls for sustainable funding for healing centres to provide the necessary supports and services to help heal the physical, mental, emotional, and spiritual harms caused by Residential Schools (TRC, 2015). As the honourable, Murray Sinclair recalls the Commission's position, he said "it is precisely because education was the primary tool of oppression of Indigenous people, and miseducation of all Canadians, that we have concluded that education holds the key to reconciliation." This statement captures the spirit of my doctoral research, to drive health education and practice, through Indigenous-led research, to support healing with and by Indigenous Peoples.

Resurgence and Reconciliation in Indigenous-Settler Relations

The two main schools of thought emerging from the complexities of Indigenous-Settler relations are resurgence and reconciliation (Asch, et al., 2018). Resurgence refers to actualizing Indigenous self-determination and cultural renewal, while reconciliation refers to increasing

understanding, positive relationships and signifies the sustainable movement of both Indigenous and Settler peoples living with the Earth, as forces for both resurgence and reconciliation (Asch, et al., 2018). The two thought pathways are exemplified by Indigenous advocates and leaders in Indigenous resurgence and reconciliation that have closely monitored Canada's progress in delivering on their promises and commitments to reconciliation with Indigenous Peoples. In response to the 94 Calls to Action, since the Final Report's release nine years ago, the most recent accountability report cites trends of inaction in reconciliation (Jewell & Mosby, 2023). The report refers to the remaining 81 unfulfilled Calls to Action and notes that zero Calls to Action were completed in 2023 (Jewell & Mosby, 2023). The researchers at the Yellowhead Institute, an Indigenous-led research and education centre based in the Faculty of Arts at Toronto Metropolitan University, have been analyzing Canada's accountability on reconciliation, and have consolidated their analyses on the recurring Five Challenges to Reconciliation in Canada (Jewell & Mosby, 2023) (Figure 1). The cited challenges include patterns of paternalism, structural anti-Indigenous discrimination, "the public interest", insufficient resources as well as reconciliation as exploitation or performance (Jewell & Mosby, 2023). The identified challenges provide valuable insights to drive positive changes within educational and health research partnerships in Canada. In relation to the health-related Calls to Action, my research advocates for furthering equity, respect, and understanding within Canada's healthcare system and for improving access, quality, and cultural relevance of healthcare research/services with Indigenous communities across Canada. Through leading the Indigenous Nation-based research partnership with Queen's University, I am advancing research that demonstrates one model to promoting reconciliation through investigation that creates an environment that respects Indigenous Knowledge systems, values, and the right to self-determination.

Figure 1: The Five Challenges to Reconciliation as published by the Yellowhead Institute, 2023

Experiential and Community-Based Approaches to Health Education

In an integrative review of the existing academic literature, the value of experiential learning and pedagogical approaches that create opportunities for learners to engage with and in Indigenous communities, is widely cited (Riediger et al., 2020). The most engaged students (Indigenous and non-Indigenous) immersed in Indigenous health-related experiential opportunities (e.g. frequent visits to community with interactive and land-based learning opportunities) have reported overall personal growth through experiences of strong emotions, notable changes in attitudes and perspectives, and success in coping with unfamiliar challenges, while also fostering positive relationships and networks across various cultural contexts (Riediger et al., 2020). Additionally, the research highlights the experiences and outcomes of health professional students undertaking Indigenous health education through their host academic institutions. The data demonstrated various inconsistencies related to quality of

delivery, methodological rigour of evaluation, pedagogical approaches, and learner experiences (Mills et al., 2018). Furthermore, at the institutional level, a university's prioritization to offer such resource-intensive programs requires increased advocacy, as the lack of prioritization of experiential opportunities is a notable barrier that poses persistent challenges to the sustainable transformation of health professions' educational opportunities (Riediger et al., 2020). Sustainable transformation extends beyond resourcing levels, and in this context refers to sovereignty, recognition and mutual respect for long-term systemic change that is rooted in upholding the right to self-determination of Indigenous Peoples (Spee, McMurray, & McMillan, 2021). Call to Action #46 from the TRC urges for the adoption of the UNDRIP as a framework for reconciliation; and calls for a document signifying collective efforts to move forward with reconciliation based on mutual respect and shared responsibility (TRC, 2015). Overall, sustainable transformation requires institutions to commit to fostering inclusive, culturally informed programs that shares decision-making power with Indigenous communities to shape and lead, ensuring that changes are meaningful, lasting, and aligned with the values and rights of Indigenous Peoples.

Manuscript 1: Leading the Development of an Indigenous Health Research Partnership: Revitalizing Indigenous Knowledge Systems

Abstract

The following chapter delves into the social, political, and historical factors influencing dominant research approaches and their impact on health for Indigenous Peoples. The juxtaposition of Indigenous and non-Indigenous research methodologies is presented as emphasized by the Eurocentric foundations of conventional academic practices, such as is the case with institutions with colonial origins like Queen's University. The manuscript advocates for a paradigm shift towards the use of Indigenous research approaches in academic processes, to underscore the necessity of upholding Indigenous rights, community-based principles and Indigenous Knowledge systems. The following manuscript shares the value in understanding the principle of collectivity and principle of reciprocity in research, to hold space for Indigenous and non-Indigenous Knowledge systems to work together, in pursuit of developing an Indigenous community-based rehabilitation and health leadership study partnership with a non-Indigenous university. Further, to build capacity in the institutional processes requires effective engagement and relationship-building through understanding the role of ethical space in conversations with Indigenous Peoples, to guide the operationalization of community-based Knowledge foundations, that are essential to informing the research purpose, questions, and outcomes of the research study. Through an emergent approach to developing the research study in partnership, I worked to enhance my skills in the research process by bridging the gap between Indigenous and non-Indigenous research paradigms, to promote an inclusive and equitable framework for health

research with community-based Indigenous research partners, and with institutional research partners.

General Introduction to an Indigenous-led Research Partnership

To increase representation of Indigenous Knowledge in research depends on decolonizing the institutional processes that are shaped by a western Eurocentric paradigm. Practicing decolonization in research, involves promoting Indigenous research processes through centring rights-based and principles-based approaches within all phases of the research partnership. Centering a rights-based approach is critical with research that involves Indigenous Peoples, as Article 3 of UNDRIP cites that Indigenous Peoples have the right to self-determination which includes the right to manage their resources, practices their cultural traditions, and govern their social and economic structures (United Nations (General Assembly), 2007). Upholding the right to self-determination supports the development of livelihoods that align with Indigenous values and Knowledge systems rather than imposed external models. The principle of collectivity supports a decolonial approach to the research process, as it supports community-led decision-making and honours Indigenous governance of the research study. Therefore, the reformation of oppressive structures in health and educational systems, must promote the right to self-determination of Indigenous Peoples. Understanding the Principle of Collectivity requires reflections by researchers and institutional partners on the impacts that a person's privilege and place in society, have on access to and experiences within the systems. Through increased relationship building efforts with Indigenous Peoples, and centering self-determining and reciprocal research partnerships, Indigenous and non-Indigenous researchers can collaborate and recognize Indigenous Peoples as experts in our/their respective and collective healing journeys. It is the role of all health system actors, such as researchers, to support self-determined

processes, as protocol in research partnerships with Indigenous Peoples. Taking actions that amplify the Peoples and lived experiences that are least represented in health and educational systems is a principal area of accountability for those in positions of power. Moreover, it is paramount that researchers are accountable to all our relations, and we must make careful choices in our selection of topics, methods of data collection, forms of analysis and in the way we share information, that does not reproduce Western-centric accounts and diagnoses of conditions (Alcock, 2019). Therefore, supporting the revitalization of existing Indigenous Knowledge systems is achieved through collaborative decision-making processes and increased understanding by researchers, of community-specific rights, principles, protocols and cultural nuances. As a first step to initiating positive relationship-building efforts, researchers can better understand diverse community-specific procedures and guiding principles, by establishing foundations of trust with regional Indigenous leaders and community members. In the long-term, the approach to positive relationship-building contributes to prospective partnership dialogues and Knowledge creation. When positive relationships between Indigenous and/or non-Indigenous researchers, Indigenous Nations and community partners, are sustained, the trust developed through working towards a shared purpose enables Indigenous community members to identify ongoing issues and harms to inform solutions to improve health outcomes with and by Indigenous Peoples in Canada.

The Right of Self-Determination in Research

In international law, it has been a journey for Indigenous Peoples to be recognised as "peoples" in a true sense, and at the forefront of the drive for the right to self-determination was for Indigenous Peoples to be regarded as subjects of international law, and not objects. One of the most critical concerns in the conflict was carving out sovereign space to exist as true subjects

and humans. Therefore, the concept of Indigenous sovereignty cannot be understood as a fixed model due to ongoing challenges and negotiations with and amongst governments. Indigenous sovereignty is flexible, and it confronts the idea of the "empire of uniformity" (Shrinkhal, 2021). Stemming out of the concept of Indigenous sovereignty is the right to self-determination, which further challenges the overarching political and principal authority of States, like Canada, to control Indigenous Peoples within their territories (Shrinkhal, 2021). By understanding the importance of upholding the right to self-determination as a decolonial research approach, contributes to the integration of Indigenous health and Traditional Knowledge into the broader health system, to revolutionize the system to focus on wellness and move away from a deficit-based focus with Indigenous Peoples. (Gallagher, 2019). To better understand Indigenous lived experiences, one must consider the effects that the absence of sovereignty has had on Indigenous Peoples' self-determination, widespread health struggles, as well as socio-political and economic resultant challenges.

It is evident that the fundamental indicator of health for Indigenous Peoples, is the right to control health decisions, services and practices through exercising the individual and collective right to self-determination (Halseth & Murdock, 2020). It is widely evidenced that Indigenous Peoples have endured generations of colonial oversight, and the right to self-determination for Indigenous Peoples globally, has been significantly eroded. By virtue of the right to self-determination, Indigenous Peoples possess the right to freely determine political statuses and freely pursue economic, social and cultural development (United Nations (General Assembly), 2007). Therefore, for health researchers to more effectively support the healing process alongside Indigenous Peoples, we must reflect on our practices to enable healing to be

generated from supporting the right to self-determination in research. What provides solace and healing to one, may not be true for everyone.

The Principle of Collectivity

The current health and wellness statuses experienced by Indigenous Peoples across Canada, are characterized by foreign governance and legal structural impositions that dominate contemporary society's leadership structures and exclude Indigenous Knowledges (Ermine, 2007). The Principle of Collectivity is a philosophy that can guide complex discussions and magnifies the voices of Indigenous leaders, Elders, Knowledge Keepers, and community (Firestone et al., 2020). Understanding the Principle of Collectivity is valuable to engage groups in holistically examining child and family health. Moreover, collectivity specifically refers to community-based governance and decision-making, as being vital to community wellness, and collectivity requires meaningful engagement of the local community in all aspects of the research processes (Firestone et al., 2020). Therefore, the Principle of Collectivity suggests that the value of collective rights predominates over individual rights. My study with Wáhta' Mohawk partners, embeds a rights-based approach and is reflective of the Principle of Collectivity with the Indigenous research partners. My study operationalizes Indigenous Knowledges through Storytelling. The study's guiding principles are culturally based by honouring the interconnectedness of all living beings including the land, water and Earth's elements, and accounts for ancestral influences, across generations, to inform current and future generations in maintaining all our relations (Blackstock et al., 2020). In practice, actualizing the Principle of Collectivity took several emergent forms, through the establishment of the IRP, which outlined how we as partners would work through the research methodology, the establishment of the CAC, and through the formation of the study's collaborative structures, research agreement and

relational approach to Elders and community members (Firestone et al., 2020). Therefore, the community leaders, Elders, Knowledge Keepers, and community partners were influential forces, decision-makers, and primary voices leading the research.

In Canada, the interrelated systems in society are centred in various forms of social exclusion that have, and continue to target the erasure of Indigenous cultures, identities, communities, Traditional Knowledge, and territories (TRC, 2015). Loppie Reading and Wien's research on social determinants of health emphasizes the interconnected impact of structural, systemic, and immediate factors on Indigenous Peoples' health (2009). They use a tree metaphor to illustrate the layers contributing to Indigenous Peoples' health: roots of the tree represent the distal causes including historical and structural issues like colonialism, the intermediate influences represented by the core trunk of the tree reflect ongoing systemic challenges such as the intermediate systems of care including political, economic, health, educational and community infrastructure, and proximal, immediate factors related to daily living conditions, access and physical environments (Reading, 2015). This model stresses that Indigenous self-determination, cultural identity, and the reclamation of Indigenous Knowledge are essential for addressing health inequities and fostering well-being. As a result of the overall disconnect within Canadian systems in understanding the deep-layered, interconnectedness of the social determinants of health, many Indigenous Peoples are faced with poorer health compared with the non-Indigenous population including, but not limited to, (Jamal et al., 2021)

- Lower life expectancy and life accidents
- Higher avoidable mortality

- Cancer and chronic diseases are among the leading causes of death in First Nations people (higher rates for colon and rectum, kidney, cervix, and liver cancers than the non-Indigenous populations in Canada)
- Inuit have the highest global rate of lung cancer (Goss et al., 2022)

Other factors that may also contribute to poorer health outcomes include: (Loppie Reading & Wien, 2009)

- Geographical challenges that limit accessibility to health services
- Affordable food and food sovereignty
- Access to education
- Awareness of anti-Indigenous racism
- Awareness of systemic racism and discrimination

Thus, for Indigenous Peoples, the removal of the right to self-determination and the perpetual collective experiences of struggle and awareness, has produced a shared consciousness coined the "mindful gaze" from Indigenous humanity (Ermine, 2007). This gaze is informed by a pre-colonial model of community, founded in shared values, a moral structure, and pursuit of justice, while living in harmony with the land, and is a "truer reflection" of human potential (Ermine, 2007). Therefore, gathering as a collective, of Indigenous Peoples to a region, is the natural environment where Indigenous Peoples discover their identity through relationships with others and the land (Ermine, 2007). Through collective organization and relationships with the land, the process of self-discovery for Indigenous Peoples reflects a more authentic form of human expression that predates colonial disruptions, and highlighs the importance of Indigenous self-determination and governance systems. Ermine contrasts the pre-colonial way of being—rooted in community, relationality, and harmony with the land—with the imposed frameworks of

colonialism, which disrupted Indigenous Knowledge systems and replaced them with hierarchical and individualistic values (2007). Thus, the reclamation of self-determination in research, requires the restoration of Indigenous Ways of Knowing, Being and Doing, where identity is shaped by collective well-being and interconnectedness with the environment (Ermine, 2007).

The "mindful gaze" described by Ermine, conveys a truer reflection, preceding colonial forces, that embodies a self-determining human community (Ermine, 2007). Therefore, researchers have an opportunity to hold space for such processes to unfold in Indigenous-centred environments and necessitates embedding relationship-building processes into the research to understand prospective research partners and contexts. Through ongoing communication in the community, researchers can begin to understand the unique contexts of shared Indigenous consciousness, shared moral structures, and environments, to effectively conduct institutionally connected research partnerships with Indigenous community. As such, my research study with Wáhta' Mohawks, was conducted entirely on the lands of our traditional territory, in Storytelling ceremony, which is the natural context and environment where the Indigenous research partners, feel the safest to discover oneself.

The following excerpt is a teaching from Səl̓ilwətaʔɬ Nation Elder, Gabriel George that further illuminates the shared "mindful gaze":

> "We've endured a lot with colonization. We've been through a lot. Some of the worst neglects and abuses that we've suffered have come though institutions. [Coming together in ceremony] is what our Elders would describe as 'untying' some of that harm…that's a word our old people use. *Yeqwethet*. Literally, it can mean to untie but it also means to heal, to make better" (Gallagher, 2019).

The powerful truth in the quote communicates the necessity to intentionally integrate Indigenous Peoples and Nations, in health research. Research contexts with institutional influence over Indigenous populations, such as with a university and Indigenous Nation-based partnership must involve Indigenous leadership. Although efforts have been made in Canada to address cultural insensitivities and inequities in health outcomes in the dominant health and educational systems, the provision of culturally informed solutions to support Indigenous populations has been largely neglected, and Indigenous Peoples continue to endure racism in the healthcare system (Health Council of Canada, 2012). In a review of relevant studies from academic and grey literature sources that focused on Indigenous research methodologies to conduct culturally appropriate research, widely reported that Indigenous Storytelling remains an important site of knowledge production, knowledge transfer and is a knowledge repository of sacred protection, for Indigenous Peoples around the world (Dennis and Minor, 2019). Storytelling can support the goal of health promotion as individuals reflect on, process and share their lived experiences, collectively. In her work *Indigenous Storywork: Educating the Heart, Mind, Body, and Spirit*, Archibald emphasizes that Indigenous Storytelling serves as a powerful medium for healing, integrating emotional, spiritual, intellectual, and physical elements (2008). She explains that Storytelling is not merely about sharing narratives but is an immersive process rooted in relationships, respect, and reciprocity. Through stories, individuals and communities find opportunities for emotional growth, learning, and connection, fostering both personal healing and collective well-being (Archibald, 2008). Thus, the process of Storytelling is a health stimulating experience, and a generationally practiced Indigenous research method that honours self-determination. For these reasons, I worked with the Wáhta' leadership to define the

Storytelling methods, for the purposes of holistically addressing Indigenous child and family health in the region.

Indigenous communities have long identified the limitations of non- Indigenous Worldviews used in academic work in accomplishing the goals they have set to articulate and implement within community-based, Indigenous frameworks (Pidgeon, 2018). Therefore, in practice, knowledge from, and within, health research must "be culturally relevant and useful, and Indigenous Worldviews need to align with the research approach to improve Indigenous health status, policy, services, and programs" (Morton Ninomiya et al., 2017). It is the knowledge produced in academic centres and disseminated via public health campaigns, that has proven ineffective to adequately serve Indigenous communities, as the externally imposed research strategies fail to take into consideration local understandings of health and wellness, with ineffective and/or non-existent engagement with local pathways for sharing knowledge (Smylie et al., 2009). Therefore, the ongoing relationship-building activities that I engaged in throughout the course of the study, reveal the negotiations I had with local community representatives, to ensure the integration of the most useful information pathways and respect for community-based schedules and cycles. For example, for researchers to conduct partnerships most appropriately with Indigenous Nations, they must understand the community-specific pathways that are preferred for regular information sharing within the population (Smylie et al., 2009). The Indigenous community research partners are the most knowledgeable experts on which pathways are the most appropriate to maximize public engagement and aligns with community-determined solutions.

To conclude, all health professionals, have the responsibility to engage Indigenous individuals in decisions regarding their health and support the development of the individuals'

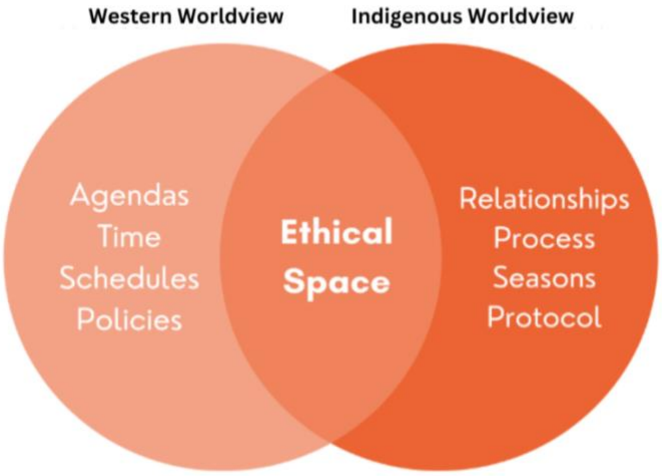
power to self-advocate (Kitty & Funnell, 2020). Moreover, for research to be successful among health and educational institutions and Indigenous Nations, the most appropriate partnership processes involves ensuring the entire research study is rooted in Indigenous Ways of Knowing, Being and Doing, because with Indigenous communities, “leading with ceremony is foundational to the success of the work” (Gallagher, 2019). To nurture relationships and develop trust among Indigenous populations and those working in the health system, researchers can inform their work based on Indigenous-determined priorities and healing practices as represented in Indigenous Ways of Knowing, Being and Doing.

The philosophy of nurturing relationships to develop trust among the research partners aligns with Ermine’s broader concept of "ethical space," which emphasizes the importance of respecting Indigenous Worldviews and fostering dialogue between Indigenous and Western systems actors.

Ethical space (Figure 1) is a central concept to understand in supporting research partnership negotiations with folks who possess diverse Worldviews (Ermine, 2007).

> “In health research, ethical space is formed by contrasting perspectives of the world, and the space offers a venue to step out of our allegiances, to detach from the cages of our mental worlds and assume a position where human-to-human dialogue can occur (Ermine, 2007).”

Figure 2: **Ethical Space Diagram (Ermine, 2007)**



Within ethical space, the research partners' Worldviews must be acknowledged in the relationship-building process. The partners' inclusive dialogues inform authentic, innovative frameworks needed to create a representative research strategy with the community-based Indigenous research partners.

Health Foundations of Indigenous Peoples

Indigenous Peoples' Ways of Knowing, Being and Doing in relation to health and wellness can be understood as multidimensional and relational. Health among Indigenous Peoples is characterized by intergenerational health indicators, diverse healing concepts, and is marked by holistic (mental, emotional, physical, and spiritual) associations to healing (Gallagher, 2019). As decades of published evidence and formative documents reveal, government-sponsored, racially fueled atrocities, continue to occur in health and educational spheres, and continue to cause harms to Indigenous Peoples in Canada. Joyce's Principle is a prime example of Indigenous Peoples calling for a more just world for our children, and future generations and

for the recognition and respect of Indigenous People's traditional and living Knowledge in all aspects of health across society (CDAM & CNA, 2020). Joyce's Principle advocates to the Canadian government and the provinces, specifically the Government of Quebec, to guarantee to all Indigenous people the right of equitable access, without any discrimination, to all social and health services, as well as the right to enjoy the best possible physical, mental, emotional and spiritual health (CDAM & CNA, 2020).

To address the systemic racism and social exclusion of Indigenous Peoples and develop effective, comprehensive health resource(s) that accurately reflect the health and wellness priorities of the distinct community, requires trust with the Indigenous leadership, and necessitates understanding of cultural identity, safety, and humility (Gallagher, 2019). For these reasons, the emphasis within any research study was to ensure positive relationships as a fundamental deliverable to reverse the generations of harmful health law, health policy and health practice that continue to erode Indigenous cultural identities (Kitty & Funnell, 2020). Therefore, by working in collaboration with community partners to identify root causes and develop a plan that engages collective healing, culture, and civic action, were areas to enhance holistic, trauma-informed approaches to health and wellness (Kitty & Funnell, 2020). To clarify, qualitative research studies present the underlying explanations underscoring why Indigenous people are disinclined to engage with the mainstream health care system: including racism, lack of Indigenous staff representation and inadequate access to cultural practices (Hadjipavlou et al., 2018). With this, it is essential to engage an inclusive breadth of community voices, especially Elders/Knowledge Keepers, when sharing knowledge and developing an interconnected health resource. A resource that protects the reclamation process of the community's cultural identities for future generations and honours the guidance of Elder(s) to promote the transfer of

Knowledge to the next generation is a unique contribution to research, that my study offers, as the roots of the Indigenous Knowledge systems, have sustained Indigenous community health and wellness for thousands of years (Gallagher, 2019).

As stated, the commitment to positive relationship building, develops trust and enables the research partners to co-identify the community priorities, and build consensus-based research approaches. Details in the Appendix include a community-informed, research agreement that was co-created with the Indigenous Nation's leadership and is steered by community-centred guiding principles. The study partners contributed to the development of the study's IRP to guide the collaborative research processes, and to ensure transparency as illustrated in the Appendix.

Principle of Reciprocity

My study was designed to include Indigenous and non-Indigenous research representatives, through a non-Indigenous university and First Nation partnership. The partnership functions to conduct research through the lens of Indigenous-led approaches, to contribute to reconciliation. More specifically, my research study partnership highlights the Health Calls to Action 22-24 (TRC, 2015).

> 22. We call upon those who can effect change within the Canadian health-care system to recognize the value of Aboriginal healing practices and use them in the treatment of Aboriginal patients in collaboration with Aboriginal healers and Elders, where requested by Aboriginal patients.
>
> 23. We call upon all levels of government to:
>
> i. Increase the number of Aboriginal professionals working in the health-care field.
>
> ii. Ensure the retention of Aboriginal health-care providers in Aboriginal communities.
>
> iii. Provide cultural competency training for all healthcare professionals.

> 24. We call upon medical and nursing schools in Canada to require all students to take a course dealing with Aboriginal health issues, including the history and legacy of residential schools, the United Nations Declaration on the Rights of Indigenous Peoples, Treaties and Aboriginal rights, and Indigenous teachings and practices. This will require skills-based training in intercultural competency, conflict resolution, human rights, and anti-racism.

Through honouring the Principle of Reciprocity, I was able to effectively engage and sustain the conditions to foster positive relationships with the First Nation leaders, throughout the prospective study negotiations and with setting up the formal Indigenous health research partnership. The word reciprocity is rooted in the French word *réciprocité,* and from the Latin *reciprocus*, consisting of *re-* (back) and *pro-* (forward) (McGregor & Marker, 2018). Together, these ideas represent the nature of fluidity that is essential to recognize between those who design the research and those who are affected by it, to be good partners in Indigenous health research. By recognizing the rights-based and principles-based approaches to research with Indigenous Peoples, set up the conditions for an effective Indigenous research partnership. The Social Sciences and Humanities Research Council (SSHRC) emphasizes the importance of reciprocity in Indigenous research, highlighting it as a fundamental value in Indigenous Ways of Knowing. Reciprocity emphasizes the mutuality of knowledge giving and receiving (Social Sciences and Humanities Research Council [SSHRC], n.d.). In SSHRC's merit review process, reciprocity is a key concept that should be evident in research proposals involving Indigenous communities. This includes demonstrating meaningful engagement and mutual benefit between researchers and Indigenous Peoples (SSHRC, n.d.). In my study, the Principle of Reciprocity was deeply embedded throughout the research process, taking multiple forms to ensure mutual

benefit and shared responsibility between all partners involved. As the Principal Investigator, I recognized my responsibility to approach the research with respect, transparency, and accountability, ensuring that the study was designed and conducted in a way that honored the values, knowledge systems, and priorities of the First Nation partners. This included actively listening to community voices, integrating their insights into the research design, and committing to meaningful collaboration at every stage.

For the First Nation-based research partners, reciprocity involved sharing their knowledge, experiences, and cultural teachings to inform the study and guide its process. Their contributions were not viewed as data to be extracted but as valuable guidance for creating sustainable, community-driven solutions. This shared responsibility extended beyond the completion of the study, with all partners committed to sustaining the findings and carrying forward the work throughout the community into the future, as outlined in the study's recommendations. This approach aligns with the Kaianerehkowa/Great Law of Peace in Mohawk (Kanien'kehá:ka) tradition, which emphasizes principles of unity, collective responsibility, and the importance of maintaining harmonious relationships within the community (Ganienkeh Territory, n.d.).

Throughout the study activities the Principle of Reciprocity emerged through the role of the storytellers in the data collection and analyses phases. For example, the structure and gender-makeup of the Storytelling research circles reflected the Principle of Reciprocity in relation to the Ka'shastensera Kontiha:wa'ne Iotiianeh:shon'/Women's Nomination Belt**.** In Mohawk tradition, the Ka'shastensera Kontiha:wa'ne Iotiianeh:shon'/Women's Nomination Belt signifies the authority and responsibility of women, particularly Clan Mothers, in nominating and guiding leaders within the Haudenosaunee Confederacy (Minneapolis Institute of Art, n.d.). This belt

reflects the matrilineal system and the integral role of women in maintaining social and political harmony. By grounding the research in reciprocal relationships and acknowledging the leadership roles as symbolized by the Ka'shastensera Kontiha:wa'ne Iotiianeh:shon'/Women's Nomination Belt and the women who led the Storytelling circles, the study fostered a long-term partnership aimed at achieving collective goals for the community's well-being. The Principle of Reciprocity in this form ensures commitment from the partners that the work does not end with the research but continues through ongoing collaboration, reinforcing trust, shared learning, and the continued pursuit of positive change for future generations. By understanding and practicing the Principle of Reciprocity, researchers contribute to the advancement of Indigenous self-determination and the respectful integration of Indigenous Knowledge systems such as described, within the broader research landscape.

Setting up the Research Relationships

The following section details the series of activities I led to connect with prospective Indigenous community partners, with the aim of developing a formal research partnership that addresses a specific applied rehabilitation and health related issue of importance to the partnering First Nation. I began to conceptualize the rehabilitation and health leadership applied research study in May 2022 which evolved into a fourteen-month period of relationship-building, with multiple prospective Indigenous community partners. The communities expressed variable interest in co-developing a regional rehabilitation and health leadership research study, which reinforced the principled-approach to developing a viable research study with the Indigenous partners and to tailor a distinctive, community-informed method to conduct research. The following steps illustrate the process I embarked on, to formalize an Indigenous research partnership that reflects the Indigenous Nation's regional health priorities.

Step 1: as the Principal Investigator, I personally authored letters of invitation to multiple Indigenous leadership representatives. Throughout Step 1, it was integral to recognize that Indigenous communities are diverse entities and understanding the Nation's specific "governance, laws, and ceremonies impact on health outcomes was wise to optimize local Indigenous governance frameworks- such as the Minobimaatisiiwin, the Great Law, Qanuinngisiarniq and other holistic concepts of living a good life" (Firestone et al., 2020). The overall focus of my proposal to the various Indigenous leaders was to formalize a partnership between community members and institutional research partners, to promote the Indigenous right to self-determination in advancing child and family health holistically, within the Indigenous community. Within Step 1, I focused on fostering reciprocity and establishing ethical space (Ermine, 2007). It was essential to appreciate the unique and context-specific values, practices, and social structures that influence the pathways of health information in the Indigenous communities (Smylie et al., 2009), to ensure access to the most appropriate means of information exchange. For example, throughout the relationship-building process, I participated in telephone calls and virtual dialogues with community leaders, as well as attended general community meetings, to better understand the nuances of Nation-specific protocols and principles related to conducting formal research partnerships.Throughout this stage, it was clear that the most relevant community-specific information to develop a viable research proposal, was revealed, only after I effectively establish trust with the community leaders. The information I gleaned throughout Step 1, I then amalgamated into an initial draft model of what evolved into the Indigenous Research Paradigm for my study (Figure 4).

Step 2: As a result of the letters of invitation and fourteen months of relationship-building with several prospective Indigenous leaders and community-based research partners, I

was invited to consult further with Indigenous First Nation representatives, in national, provincial, and territorial circles. I attended Indigenous community events, including a national Annual General Assembly (AGA) in May 2023, where over forty First Nation government regional delegates and national representatives provided comprehensive synopses of their community's social, cultural, environmental, and economic trajectories for the coming years. The opportunity to observe the AGA, as well as receive feedback from several leaders representing their respective First Nations, helped to narrow the scope of a broad rehabilitation and health leadership research proposal to a more specific study topic focused on Indigenous child and family health. As a result of the extended period of information gathering and intentional relationship-building, I identified a select group of three First Nation leaders to follow-up with who expressed interest in further discussions related to the research proposal.

Step 3: The ensuing consultations with the three separate prospective research partners who were leaders of three separate First Nations, included multiple in-person travels to various regions across Ontario, to considering potential research environments for a child and family focused study. The deliberations were centred on the Indigenous community's priorities to generate and transfer knowledge among the generations in the community and were characterized by pragmatic discussions around the operations of the First Nation-managed departments, such as the cultural, health, social, housing, and educational departments. Throughout the meetings I shared relevant information from the institutional side of the prospective research partnership. Information sharing with the First Nation leaders consisted of Queen's University's doctoral program trajectory and estimates of study timelines to produce the research deliverables within approximately one year. Additionally, I explored the most appropriate ethical protocols to negotiate with Queen's University, that reflects the practices of

Indigenous community-based research partners most appropriately. This phase of the partnership-building efforts involved transparent communications regarding the Doctor of Science program requirements in Rehabilitation and Health Leadership, the affiliated research partners at Queen's University and the innerworkings of the Health Sciences Research Ethics Board's (HSREB) data governance and institutional requirements, to confirm the First Nation's acceptance of academic requirements- to uphold the right of self-determination. Prior to the formalization of any partnership, transparency on behalf of the institutional partners related to personal, communal, academic, ethical, and legal boundaries to the research was essential. I had approached three First Nations initially, to discuss potential collaborations, and due to a series of reported leadership changes, community member burn-out and lack of trust with the University, one First Nation of the three, expressed sustained interest in supporting my proposal to partner on an Indigenous child and family health study. The First Nation partners on the study are Wáhta' Mohawks, my family's home community.

Step 4: I worked with the leadership in Wáhta' to propose the research agreement and after iterative revisions with the Chief and Council, I formally received approval of Wáhta' Mohawks willingness to partner on my doctoral research study. The formal partnership outlined the Nation-specific research protocol to adhere to, to maintain the research rights of the Nation.

The conceptual notion of reciprocity is threaded throughout the "Relationship-Building" centre of the IRP (Figure 4). The conceptual approach is rooted in positive relationship-building, and one way of fulfilling this, is through the knowledge exchange between and among the research partners. By establishing a foundation built on knowledge sharing, the vitality of the research partnership increased. Reciprocity in research represents a promising approach to address historical injustices in research partnerships between Indigenous Peoples and non-

Indigenous researchers, and to proactively remediate any anticipated challenges.

Conclusion

Leading the development of a new research partnership that centres Indigenous ceremony as research, such as honouring Storytelling practices, is an important contribution to the success of an Indigenous health research study. The process of leading the creation of an institutional-based and Indigenous Nation-based research partnership began with a series of meetings, in which I engaged in various forums with Indigenous leadership and participated in prolonged dialogues with the goal of negotiating a research proposal for an Indigenous-informed health research study.

However, during discussions with prospective partners and leaders of the Indigenous communities, two of the three community leaders in partnership conversations, ultimately chose not to proceed with establishing an institutional and Indigenous Nation research partnership. Various reasons were reported by the Indigenous leadership councils for declining the partnership proposals, including a changeover in leadership within one Indigenous Nation, unfamiliarity with Queen's University and inconvenient timing for the proposed project timeline. However, of the three communities, the one with the unwavering willingness to support the development of a culturally relevant health research partnership was the leadership at Wáhta' Mohawk Territory. In collaboration with Wáhta' leaders, the iterative development of the study ensued, including the Indigenous Research Paradigm illustrated in the next chapter, which identified the Storytelling and Storywork research methods conducted within the Indigenous Nation. The process supported intergenerational knowledge-sharing which effectively guided the partnership and upheld sacred cultural practices and principles to enhance the overall study

connections and to support Indigenous Ways of Knowing, Being and Doing in health research and practice.

Manuscript 2: Upholding the Right to Self-Determination through an Indigenous Research Paradigm and Storytelling to Advance Child and Family Health in Wáhta' Mohawk Territory

Abstract

The following manuscript *Upholding the Right to Self-Determination through an Indigenous Research Paradigm and Storytelling to Advance Child and Family Health in Wáhta' Mohawk Territory*, reports on the identities of folks in Wáhta' as well as individual and collective lived experiences throughout the life course, to inform the child and family health priorities in Wáhta' Mohawk Territory. The study protocol describes the operationalization of the research and informs the Indigenous Research Paradigm (IRP) features, which guides the research in its entirety. Through the co-creation of an IRP, the study partners refined the research design and implementation process to reflect the Wáhta' Mohawks' distinct Indigenous values, healing principles and Knowledge systems. This chapter underscores the importance of culturally relevant methodologies and demonstrates how Storytelling practices are viable methods to generating, reflecting and analyzing health experiences with Indigenous research partners. Overall, this chapter presents insights to advance community health priorities regarding Indigenous children and families. The recommendations reported from the study are intended to inform the local Cultural Healing Centre's (CHC) Indigenous child and family health programming, with an emphasis on child development in the early years, in Wáhta' Mohawk Territory.

Introduction

The First Nations Health Authority (FNHA) is a provincial health service delivery organization, in British Columbia, that operates as the first of its kind partnership model in Canada (FNHA, 2023). The Indigenous-led governance and advocacy of the FNHA in advancing Indigenous-led health priorities is important to consider in my research with Wáhta' Mohawks, as it provides an example of activating cultural safety and humility through a research partnership. For example, FNHA is responsible for administering a variety of health programs and services for First Nations Peoples, and their influence expands beyond the political borders of British Columbia. The FNHA conducts their business with the mainstream health system in Canada by conveying that health and wellness are fundamentally interconnected and operationalizes initiatives through partnerships that value reciprocal accountability, which depends on responsible contributors understanding the importance of cultural safety and humility (FNHA, 2023). By embracing reciprocal accountability, research partners can maintain their respective responsibilities and uphold their unique accountabilities to one another, in the pursuit of common goals (FNHA, 2023).

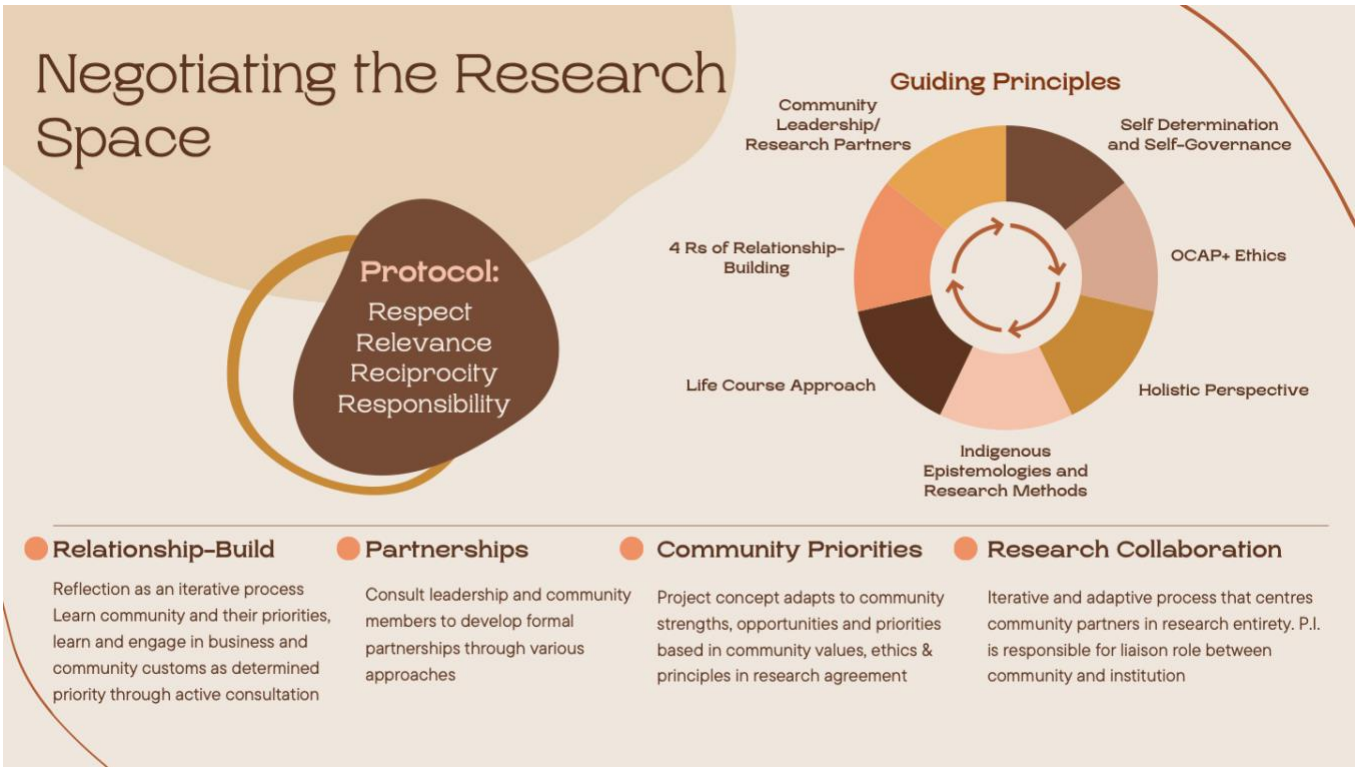
Moreover, the FNHA developed the first Cultural Safety and Humility Standard for health and social service agencies in British Columbia and over the next three years, in partnership with the Health Standards Organization, the Winds of Change: Cultural Safety and Humility Standard will be expanded across Canada to health and social service organizations to assess whether organizations are conducting their programs and services according to the new standard (Nowgesic et al., 2024). The Winds of Change standard is intended to support wide-spread calls to advance cultural safety and humility in the health system to address anti-Indigenous racism and harmonize the design in health and social services delivery of care

(Nowgesic et al., 2024). The Winds of Change initiative offers a research partnership model that prioritises Indigenous Knowledge systems and promotes Indigenous Peoples needs with attention to building capacity in the health system to endorse cultural safety and humility (Nowgesic et al., 2024).

In relation to the cultural safety and humility standard, I led the development of the research partnership with delegates in Wáhta' and at Queen's University, by engaging in regular communications that prioritised approaches to engagement that reflected these standards. I worked in the spirit of humility and openness to learn, to proactively embed Indigenous community-based approaches into the research proposal design, and centre community-relevant guiding principles. The research plan and accompanying guiding principles were co-developed with the University and First Nation-based research partners. Through several working meetings with the Chief and Council as well as the CHC leads, in person and by telephone, I facilitated the co-creation of a process that identified relevant protocol features and guiding principles to inform my study. (Figure 3) Negotiating the research space revealed the key areas of focus for the study protocol that served as origins to the components of the IRP. The study protocol highlighted the guiding principles to the research partnership which included the adherence to respect, relevance, reciprocity and responsibility in research. In their work, Kirkness and Barnhardt argue that research with Indigenous Peoples should be guided by mutual respect, culturally relevant goals, reciprocal benefits, and a deep sense of responsibility to the community (1991). These principles encourage researchers to consider Indigenous perspectives and Knowledge systems, leading to more equitable and meaningful research collaborations. Furthermore, negotiating the research protocol took several emergent forms including

relationship-building activities, partnership-development, identifying community priorities and overall research collaboration (Figure 3).

Figure 3: Protocol, Guiding Principles, Study Phases



Importance of Indigenous Methodologies

Indigenous research methodologies are rooted in Indigenous epistemologies, and therefore distinguish themselves from qualitative approaches from western history and other non-Indigenous intellectual traditions (Kovach, 2009). By honouring Indigenous research methodologies through the integration of ceremonial aspects coupled with the conceptual, paradigmatic foundations that centre Indigenous Worldviews and Knowledge systems, researchers can actualize Indigenous-led solutions. Furthermore, in my study, the IRP activates the distinct Nation-based methods and health principles, to ensure the research is intrinsically connected to the Wáhta' Mohawks' Knowledge systems.

In my study, the Indigenous Worldviews and Indigenous Knowledge systems are further revealed through the shared stories in the data collection phase. The stories shared by Indigenous storytellers are distinct scientific knowledge-wells and Storytelling is a vital means of transmitting that knowledge (Lipe, 2013). My study operationalizes traditional Storytelling methods via sharing circles to promote reflections of personal narratives and traditional teachings.

In addition, Indigenous Knowledge systems emphasize the importance of relationships: relationships to place, to each other, to the stories, and to the storyteller (Lipe, 2013). Indigenous Worldviews and Knowledge systems in my study underscore relational accountability, through reciprocity, where the research partners are accountable to upholding the Indigenous right to self-determination and to elements in the research environment, to hold culturally safe space for Knowledge sharing. The Indigenous Worldviews and Knowledge considers Indigenous child and family health holistically, and is connected to place, happenings, and experiences - as the mothers and aunties would have experienced them and passed them to the next generation (Kovach, 2009).

Research Agreement

After several months of relationship-building, by fall 2023, I had engaged in conversations with the Chief of Wáhta' Mohawk Territory, to formally submit a research study proposal for official sanctioning. The Research Agreement was refined through feedback received via email and telephone correspondence with the Chief and was formalized through a collaborative agreement between Queen's University, Wáhta' Mohawks, and additional community-based partners.

The Research Agreement included the following documents, as detailed in the Appendices:

1. Terms of Reference (TOR),
2. Memorandum of Understanding (MOU),
3. Ethics agreement with Wáhta' Mohawk leadership

The partnership agreement expanded upon the initial IRP which I led the co-development of through consultations with the research partners the Chief and the CAC. The consultations to codify the research agreement, required the refined research focus, particularly in the context of examining Indigenous child and family health, through Storytelling practices, at the community-based CHC. The research agreement emphasized the use of Storytelling as a culturally relevant method for data collection, that aligned with Wáhta' Mohawk research protocols and cultural principles. The study's ethical framework was founded in conducting research according to Indigenous Knowledge systems, through upholding Indigenous self-determination, transparency, respect, reciprocity, relevance, and responsibility (Kirkness & Barnhardt, 2016).

Through negotiations with the Chief and Council, a comprehensive research agreement was co-developed by integrating the right to self-determination, highlighting related cultural principles and community benefits based on the research partnership to support health and wellness. The structure of the research agreement provided the foundation for successful research collaborations by detailing the foundational principles and data management expectations to adhere to culturally appropriate protocols regarding the study's terms of engagement between Queen's University and Wáhta' Mohawks research partners.

The reciprocal research partnership formalized within the Research Agreement's centres the study in the First Nation-specific self-determining and sovereign data processes and

principles. In addition to articulating compliance with Ownership, Control, Access and Possession (OCAP®), the community-determined principles within the Research Agreement signify a circulating responsibility on behalf of the Indigenous Nation-based and institutional research partners. The responsibilities include to teach and share what has been learned through personal lived experiences, in the Storytelling research, for the improvement of child and family health by passing on knowledge between generations (McGregor & Marker, 2018). In preparation for the development of the research partnership, the Chief and Council and I codified the OCAP® principles in the Research Agreement, by articulating that the research information and rights reside with the Indigenous rights-holders, including the Indigenous leadership, the CAC, and the study participants - the storytellers. The agreed upon OCAP® principles were articulated in the research agreement and are upheld by my due diligence as the Principal Investigator throughout the research study.

Indigenous Research Paradigm

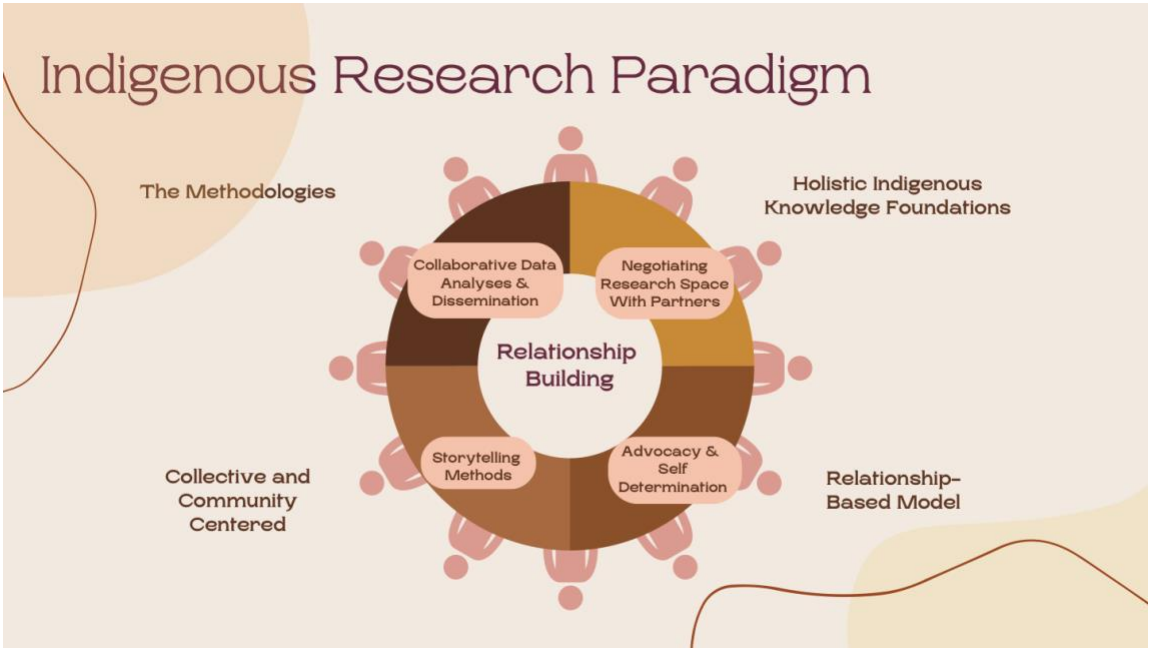
The IRP (Figure 4) is a guiding model that I drafted through an environmental scan on Indigenous-led research models and then further refined in collaborations with the Chief and CAC within Wáhta', during the formalization phase of the Research Agreement. The IRP is structured by a set of key principles that inform the study's phases and governance. The conceptual framework presents a different way of mapping out a research model, based on holistic intellectual, philosophical, ideological, and cultural premises (Brown & Strega, 2015). The IRP crafted for my study, prioritizes four interconnected areas to inform and guide the study process. The IRP focuses on negotiating the research space with the research partners to apply the most appropriate knowledge foundations within the study and reinforcing that Indigenous Knowledge systems are legitimate and foundational to the entire research process. Further, the

model of engagement to inform the IRP is reciprocal and relationship-based, with emphasis on continuous reciprocal accountability, to engage with Indigenous methodologies to co-interpret the data and its impacts on healing–including Storytelling (Brown & Strega, 2015). The IRP's fifth area, its central core, is defined by positive relationship-building through research collaborations between the partners in the Indigenous community and institutional research partners. The IRP holistically emphasizes the cyclical, iterative approach to relationship building with First Nations that was the most effective method to engage with the community delegates. This approach to designing an IRP, led by Wáhta' Mohawks, with the foundations of Haudenosaunee culture are highly significant to health science research as "these teachings were practiced pre-contact,[…] passed down through oral traditions, ceremony, and relational concepts" and the Western-informed folks, are only now starting to appreciate their true value (Pazderka et al., 2014).

Overall, the holistic nature of the IRP is flexible and guides with the study objectives to engage in community-led, collaborative Storytelling and Storywork interpretation methods, to inform Wáhta's child and family, health, and educational priorities. Overall, the Storytelling research offered the most appropriate de-colonial data collection method, as it is a central focus of Indigenous research approaches and epistemologies (Iseke, 2013). Storytelling accurately reflects the existence of multi-dimensional experiences and diverse realities, that are characterized by expansive concepts of time and space, and that are honoured through the open-ended and collaborative nature of the research process (Blackstock et al., 2020). To elaborate, the Storytelling research involved ceremonial aspects of the Indigenous partner Nation in the Storytelling research. This was accomplished through collaborative relationship building, where the research partners produced a consensus-driven, comprehensive Research Agreement. We

ensured the integration of an ethical, principled research partnership with an intention to make decisions pertaining to community health that considered the future generations. By adhering to the local protocols such as the Cultural Healing and Health Principles (Appendix C), and by honouring the partnering community Elders and the CAC, contributed to culturally sensitive research environments. As a result, the process of collaboration to inform the IRP alongside the overarching Research Agreement maintains existing Indigenous Knowledge throughout the course of the study, and accounts for regional resources that are essential to advance and sustain Indigenous child and family health.

Figure 4: Indigenous Research Paradigm (IRP)



Purpose and Research Questions

After formalizing the study phases and features into the IRP, the research partners (myself and the CAC) further expanded on the study purpose to uphold the right to self-determination through the holistic examination of child and family health, by formulating the research questions. The overall research purpose aimed to report on Indigenous community

members' health and social experiences, with the intentions to inform the community's early years programming for children and families. As mentioned, the study was conducted through a non-Indigenous health and educational institution and Indigenous Nation-based research partnership. The CAC and I collectively determined the child and family-related subject was best explored through the following research questions:

• *How can Indigenous and non-Indigenous researchers collaborate in academic spaces that engage Indigenous Knowledge and Ways of Knowing, Being, and Doing, in the context of a First Nation's Cultural Healing Centre's programming for children and families?*

• *What are the Wáhta' Mohawk members'/residents' individual and community health priorities?*

• *What are the most appropriate ways to share the stories to inform the First Nation's long-term child and family health and educational programming and services?*

Methods - Setting and Participants

My study sought to uncover the understandings, experiences and priorities for child and family health in Wáhta' Mohawk Territory, to advance Indigenous community-led and governed Knowledge systems through a community-based research partnership. The study partners from Queen's University and in Wáhta' Mohawk Territory collaborated over the span of nearly two years, to create an applied health science research project that utilized Indigenous Storytelling methods to address a community-determined priority. After the initial research proposal was reviewed by Wáhta' leadership, the CAC and I collaboratively developed the study details by confirming the data collection method of Indigenous Storytelling with the CHC program participants. The methods were further refined by the CAC, to reflect cultural traditions throughout the process of the data analyses through collaborative Storywork. In my study, the Storytelling research was guided by local First Nation (Kanien'kehá:ka/Mohawk) Elders and

Knowledge Keepers in the region and included Kanien'kehá:ka/Mohawk cultural tenets and elements of the community such as use of Kanien'kéha/ Mohawk language of Wáhta' Mohawks, in the overall study protocol and conduct. The Storytelling research sessions were conducted in circle protocol, in person with participants of the early years Mom/Parent and Tot programs, at the CHC in Wáhta' Mohawk Territory, to uphold the community-led approach to the research. It was essential throughout the study to maximize parental/guardian engagement to increase representation of the shared Indigenous Knowledge as well as the diversity of lived experiences within the families in the community. As the study recommendations were intended to inform the early years child and family health program at the local CHC. The study underwent and received approvals from two separate formal ethics governing bodies within the Wáhta' Mohawks Chief and Council government, as well as through the Health Sciences Research Ethics Board (HSREB). The challenge in aligning the two Knowledge systems through one mutual Research Agreement, and study record-keeping, with attention to upholding the Indigenous partners' right to self-determination throughout the ethics processes, required a significant amount of advocacy and negotiation from me on behalf of Wáhta' Mohawks' interests and broadened the standard institutional research partnership models.

The formal recruitment strategy for the Storytelling research was facilitated by the community research partners – the CAC, through word-of-mouth, and by sharing the recruitment poster in the community newsletter (Smylie, 2009). In preparation for the community data collection days, the CAC distributed the recruitment poster and shared information to the "Mom/Parent and Tot" program participants two weeks in advance of the planned Storytelling research days in the Fall of October 2023. The two Storytelling circles were organized to occur on two mornings throughout one week, of the "Mom and Tot" program's schedule. During the

two weeks prior to the Storytelling circles for the research, the community residents in Wáhta' were invited to learn more about the study goals and could elect to participate in the study as contributing members of the CAC and/or to partake as storytellers in the sharing circles, if eligible. The purposeful sampling of the parents/guardians who regularly access the "Mom/Parent and Tot" program was completed by the CAC. At the advice of the CAC, to enhance community engagement, the two Storytelling sharing circles were scheduled for two of the mornings of the regularly scheduled "Mom/Parent and Tot" programming at the CHC.

I was in regular communication with community via telephone and email, and ensured I initiated regular check-ins to support the CAC. The inclusion criteria for storytellers required the participant to be a current parent/guardian of one of the child members within the "Mom/Parent and Tot" program, or affiliated with the program, at the CHC at Wáhta' Mohawk Territory and be at least sixteen years of age at the time of data collection. The exclusion criteria stated those who were not a parent/guardian of a child member of the "Mom/Parent and Tot" or involved with the CHC program at Wáhta' Mohawk Territory, or under the age of sixteen at the time of data collection were ineligible to be a storyteller/participant.

Methods – Procedure

The following question prompts were used to guide the Storytelling research. On the data collection days, the interested research participants and I gathered in a circle at the CHC. I read aloud and shared virtual copies (with a tablet) of all the questions that were to be posed throughout the Storytelling research, at the beginning of the Storytelling circles and repeated them as requested by the storytellers. The use of the semi-structured interview questions provided a organised, yet flexible approach to elicit comprehensive and in-depth conversations and articulations of child, youth and family health and wellness in relation to the members' of

the circle's lived experiences in Wáhta' Mohawk Territory. The guiding questions were as follows:

1. How do you identify as an Indigenous person, or parent of an Indigenous child, living in a First Nation community in the larger context of what is now Canada?
2. What does health mean to you and is this conceptualization shaped by your identity as an Indigenous person/community member/parent of Indigenous child?
3. If you could provide a teaching through Storytelling to an educational helper or care provider of your children, about health and wellbeing, what would it be?
4. In your experience with the Cultural Healing Centre's child and family operations, what have been the most impactful learning opportunities your child has experienced, what have been the least impactful learning opportunities available to your child?
5. In your experience with the Parent and Tot/youth programming operations, what have been the least impactful learning opportunities available to your child?
6. If the Parent and Tot/CHC prioritized culturally-informed pedagogy and class teachings, how would you feel as a parent of child(ren) attending the programming?

To begin conducting the Storytelling circle(s), I opened the circle with a personal introduction in Kanien'kéha (Mohawk language). I then reviewed the letter of information and conducted a verbal informed consent process with each storyteller. As a final step to obtaining informed consent from the storytellers, the opening of the circle included collective training for the circle to review the Storytelling circle guidelines, pertaining to Indigenous Storytelling research, and rooted in the traditional Cultural Health and Healing principles of Wáhta' Mohawks and generations of oral tradition (Archibald, 2008). The guidelines adopted by the Storytelling circle members included rules of engagement to set the context for the research

dialogue. The core principles of the sharing circles included consent, confidentiality, trust, respect, reciprocity, and honesty. The circle governance was characterized by collaboration and shared decision-making throughout the research process. The research partners' commitments to ensuring respectful engagement to cultural protocols and research was also reiterated. In line with Indigenous teachings, the sharing circles were not time-bound but ended when the circle members felt all had been said. Although the research partners could not guarantee the maintenance of privacy by the other participants, outside of the circle sessions, the rules of engagement set the tone and collective expectations for a safe, collaborative environment to exchange stories.

Throughout the consent process, I clarified any outstanding questions regarding the responsibilities of the storytellers and obtained the interested parents'/guardians' verbal consents. A total of seven parents/guardians were eligible storytellers (n=7) in the Storytelling study. The storytellers were requested to report on their sex and gender identity(ies) and to create a pseudonym for the Storytelling processes to ensure their identities remained confidential and anonymous. The sharing circles were audio recorded and before a storyteller started to share their story(ies), they would disclose their pseudonym for clarity of speakers and accuracy of interpretations throughout the Storywork analysis phase of the study.

After obtaining consent, I presented the storytellers with four open-ended questions relative to the community child and family health, and educational programs, to guide the research circle. The option to share stories in a one-to-one session was also presented, dependent on the storyteller's preferences and comfort level, however every storyteller (n=7) elected for the group Storytelling sharing circle structure.

Ethics

The stated short-term risks associated with partaking in the sharing circles were possible feelings of stress or uneasiness related to discussing the needs of their child(ren), and the possibility of fellow community members being present within the sharing circle and speaking about personal health, cultural, or lived experiences. There were no long-term risks associated with participation in the sharing circle(s). A direct benefit of participating in the study was the opportunity to learn about the ongoing community efforts to improve early learning and child development offerings from a culturally rooted standpoint. There was also local support information provided and additional resources for telephone support lines offered to ensure participant well-being. The data collection days were enabled by the ongoing guidance from the community's Mohawk Elders, as well as the CHC's openness to host the research study. The respected community helpers provided wisdom on the importance of Indigenous Knowledges and sustaining generations of intergenerational wisdom.

To protect the privacy of the storytellers, all information collected during the Storytelling sessions was kept confidential and anonymous through my role of caretaking for the study tablet and password-protected laptop, in accordance with the OCAP® parameters on information governance. Personal identifying information such as names, addresses, and contact information was not to be collected or recorded. Instead, pseudonym names were used to identify the participants in the research through data analyses and dissemination phases. Most of the storytellers opted to choose pseudonyms in their Indigenous language and/or that represented animals and nature, instead of electing for pseudonym numbers. The aversion among the storytellers, to be referred to as a number compared to an Indigenous word, animal or land-based name was a unique study feature and highlights the decolonial approach taken to challenge the standard models to institutional health research and numerical pseudonyms. All data collected

during the Storytelling sessions was stored securely to protect the confidentiality and privacy of the participants on a research study-tablet. I transferred the audio files of the Storytelling circles to ensure data was securely transferred to and stored on a password-protected computer with restricted access for the CHC/Chief and Council delegates and for me as the Principal Investigator to be transcribed, and permanently deleted from the study tablet. There were no hard copies of the data produced throughout the study. The transcribed data that was collected during the Storytelling sessions was retained for the duration of the research project and is articulated to be governed and stored by Wáhta' Mohawks Chief and Council delegates, the CHC leads as requested, and stewarded by myself (the Principal Investigator) for the duration of the study. All data collected for the purposes of the applied research project parameters, post-data analyses, was stored securely by me, as a delegate of the First Nation and student at Queen's University, and is to be destroyed after 5 years in the institutional research ethics board records by supervisor Dr. Janet Jull at Queen's University.

Overall, the research project underwent formal ethics review processes to ensure that the privacy of the research partners/Storytellers are protected. The ethics approvals were obtained from the Health Sciences Research Ethics Board (HSREB) at Queen's University, that assessed the potential risks and benefits of the research project. Wáhta' Mohawks Chief and Council also reviewed the agreements from their Leadership, Ethics and Legal review boards to formally sanction the research partnership. To conclude, genuine reciprocity in research is achieved when the institutional, in our case, Queen's University researchers pursue deeper understandings of Indigenous Nations to support Indigenous Peoples in driving the innerworkings of the research and by supporting access to the institution and its representatives, to which they are being introduced to, in the study (Kirkness & Barnhardt, 2016).

To ensure the appropriate Wáhta' community storyteller access to and possession of their respective data after the Storytelling circles concluded, I emailed the storytellers electronic records of their raw study data transcripts (their stories) to collaboratively code the data. The CAC and I also maintained regular and transparent communications via email, and in person check-ins, to ensure the data stewardship processes articulated in the Research Agreement were carried out through consultative and transparent means with the community research partners. As specified in the research agreement, I was the first point of contact as a data steward assigned to manage and control the raw data via electronic storage and the same access was available to the CAC and CHC leadership, upon completion of the analyses, to access the data for uptake and strategic planning purposes. Queen's University will retain the publication of the study analyses and the research recommendations. The collaborative approach to managing the electronic data contributes to constructing a positive and productive rapport amongst the Indigenous community-based and institutional-based research partners, as well as respects the right to self-determination of Indigenous Peoples, specifically in relation to data governance.

Results: Community Analyses and Findings

As defined in the IRP, the thematic coding, and data analyses of the Storytelling data, were completed in collaboration with the Storytellers which increases the credibility and trustworthiness of the study process and conclusions (Creswell & Creswell, 2018). The story analyses occurred both in-person and through virtual communications, such as email, for accuracy purposes. I sustained the Storywork process from the circle dialogues, with a virtual follow-up to collaborate on an iterative, 7-step- reflexive, thematic data analyses (Braun & Clarke, 2022). The collaborative coding of the stories, with the storytellers, ensures all accounts were framed with in-depth, accurate and holistic understandings of experiences within the social,

political, and historical contextual considerations (Braun & Clarke, 2022). Throughout the continued Storywork process, storytellers were invited to review the sharing circle transcripts after their respective sharing circle and provide additional thematic interpretations and insights into details reported from the initial coding of their story data. The various quality assurance strategies included member checking and iterative revisions to the data coding and data visualization processes. As a result, the storytellers redacted or removed components of their data or identifying features from their stories to ensure maximum anonymity, as well as to better articulate the values or teachings in the stories, through the iterative process of Storywork.

Throughout the meaning-making process (Storywork), the descriptive analyses more accurately reflected Indigenous Knowledges and the storytellers' experiences. The Storywork ensured that I, as a researcher, did not ascribe meaning to the stories and descriptive data, but the meanings emerged from collaborative thought and dialogue from the storytellers, supported through the Storytelling research ceremony itself. By expanding on the ontological foundations of the study, Storywork reinforced the notion that there is not one observable truth, but reality is constructed from multiple, subjective lived experiences and the diverse realities can be captured through the open-ended and collaborative research method. The Storytelling circles illuminated Indigenous-specific health experiences and priorities, in relation to western-informed dominant conceptualizations of health and wellness. The data collection methods supported an evolving, collective understanding of Indigenous perspectives of health and social priorities, from culturally and community-informed positions. A strength of the Storytelling research was evidenced in the fluid yet in-depth recounts of socio-cultural and historical experiences, that shape contemporary child and family development within the community.

Storywork: Meaning-Making

To summarize, the Storywork from the two Storytelling circles revealed 117 codes, that were synthesized into 11 thematic groups, and then categorized into three primary themes to concisely frame the information. The three primary categories provide in-depth descriptions and recommendations pertaining to the themes of:

1) Identities at Wáhta'

` 2) Sources of child and family health and wellness in the community

3) Specific strengths, barriers and opportunities for health and wellness growth in Wáhta'

To further inform the community-analyses phase, the most appropriate avenues to share the stories, within the community contexts were identified by the storytellers. The goals to support self-determination and promote community-wide uptake were identified early in the research relationship-building, to leverage the Storytelling recommendations to inform and sustain the child and family health centred operations at the CHC. Overall, the study reporting and Indigenous Knowledge Translation (IKT) products are intended to be utilized by the First Nation and research partners. The products are projected to inform strategic directions, and provide the direct evidence needed to revitalize the programming to better reflect the priorities of the children, youth and families accessing programming at the CHC.

The first of the three thematic categories offers insights into the identities that make up the Wáhta' community and who shared their stories related to Indigenous child and family health in the community. The second prominent theme within the story data provided deeper understandings of health and wellness conceptualizations that exist among the storytellers, perspectives from Indigenous and non-Indigenous parents/guardians. Thirdly, the Storywork identified the perceived strengths, barriers, and opportunities to pursue in relation to enhancing community health and wellness, within the sphere of the CHC's programming in the First

Nation. The Storywork themes included:

1 – Identity(ies)/The Community at Wáhta'

The storytellers grounded their stories by self-identifying themselves in relation to the study's child and family context, by disclosing their familial roles and intentions for the Storytelling sharing circle. The Storytelling process illustrated the diversity of identities of individuals living in Wáhta' Mohawk Territory and the various impacts of having Indigenous identity(ies) and/or non-Indigenous identity(ies). Storytellers described the multiple layers involved in growing to understand and fully express one's identity(ies). In relation to health and wellness, it was presented by parents/guardians of children currently being raised in the community that there are significant variations in the reported perceptions of oneself, and wellness statuses among the storytellers. One's sense of self was also identified as a health indicator amongst the storytellers. The notion that the development of one's identity is dependent on accessing healthy practices was conveyed. Furthermore, the idea that feelings of wellness were dependent on place and community connectedness, was frequently mentioned.

The storytellers further self-identified in relation to place. The various self-locations included community members who have grown up in Wáhta' Mohawk Territory and moved away in adulthood to then return to Wáhta' later in life, individuals who had never grown up on territory and had moved to Wáhta' in adulthood, and members that grew up on territory and have always lived in Wáhta'. Among the diverse profiles of the storytellers, it was unanimously expressed that health and wellness improved when physically located within Wáhta' and other First Nations, and when able to access opportunities for learning, cultural connections, and access to land-based healing practices, versus living within other jurisdictions.

One storyteller discusses their Indigenous identity growth since moving to Wáhta' in their adult years.

> "My identity has grown. My identity as Indigenous since being here in Wáhta' versus when I was off territory as a person who grew up off territory. So, in the last five-six years being on Territory I've grown in my cultural connection. Much to be learned when able to be connected to a community" (Toka, personal communication, October 26, 2023).

Another storyteller recalls their adverse childhood experiences and residual traumas into adulthood because of growing up in the First Nation community and attending school away from the community.

> "School was, I was always ashamed of who I was because the kids did tease. They weren't physical to me, but their words were very hurtful. And then when my parents were speaking Mohawk in public, I was like, I wanted to dive under the table at restaurants because people were staring. But they were very strong and very proud and did not stop speaking their language. Wherever they were. So, I'm thankful for that. And I am learning, it's all in my mind, it's all the knowledge. It's just, I think, getting over those issues of being, you know, humiliated and once I likely work through that, I think it'll all come out" (Turtle/a'nó:wara, personal communication, October 26, 2023).

The Storytelling data reported the generations of anti-Indigenous racism and colonial harms that have suppressed Indigenous individuals and communities throughout time and space. The reported experiences were connected to being Indigenous and compulsory attendance at formal schooling, off Wáhta' Mohawk Territory, which was characterized by white-settler, Euro-centric governance, leadership, and Worldview. The stories detailed ongoing challenges to

nurturing proud Indigenous identities among youth and families, as generations of emotional, physical, mental, and spiritual violence produces compounding emotions of shame within Indigenous communities. The storytellers recounted the persistent intergenerational traumas inflicted on children and families, from the experience of Canada's Indian Agents coming into Wáhta' Mohawk Territory to separate children from their families, to live and attend schooling off Territory. Among the stories was the noted necessity to positively work through colonial traumas by strengthening overall self-acceptance of one's identity, to promote healing.

One storyteller detailed the emotional journey of claiming their Indigenous identity and reconnecting with their cultural understandings for themselves and their children.

> "We just moved up here, so we have been disconnected. I'm feeling like I'm reconciling a lot of things in myself for my children. Like their lines, you know they're going forward and they're my descendants. So, it's emotional, it's sad. It is, it is. And you don't know what you don't know … I'm reconnecting to my Indigenous identity. Really, I feel strange about it because I've been existing between places and I'm helping steward my children through this. And building their cultures. So, I don't know how to identify it. I'm just kind of learning what that is for me. And I feel very strongly about how it's silly how the government can give you status. I really have a problem with how that is because that feels wrong, you know, with their history in the government" (Rooster, personal communication, October 26, 2023).

Another storyteller shared the importance of identity acceptance to enhance collective health and wellbeing.

> "And with identity comes acceptance. I guess identity is first knowing who you are. Being able to feel included and accepted in community to build those relationships. If

> you have a strong identity and knowing who you are and what gifts you have, to contribute, to bring to others and to community is helpful to integrate into community and to accept others. If you're healthy yourself, right? If you can use that good mind in your relationships with others and those things in nature, then it's easier to have a healthy collective" (Toka, personal communication, October 26, 2023).

An additional notable pattern emerging from the collaborative Storywork, was the storytellers' identities and experiences as cisgender women (assigned female sex at birth and identifies their gender as a woman) in society and in relation to the land. The storytellers noted intersectional identities and detailed multipart experiences as women spanning the ages of early adulthood to ninety-five years of age, with stories shared across the human life course.

Furthermore, the storytellers detailed the several roles and responsibilities they fulfilled in their lives. Among the designated roles were, Mohawk mothers, grandmothers, Elders, and non-Indigenous mothers. The Kanien'kehà:ka/Mohawk Nation representation was far reaching with described familial ties to Kanehsatà:ke Mohawk community in Oka, Quebec, Mohawk from Six Nations of the Grand River, Ontario and Wáhta' Mohawk Territory, Ontario. Storytellers also reported ancestry of Ojibway, Innu, and Scottish, along with other non-specific, non-Indigenous identities. The importance of developing strong identities in the context of historical experiences and traumas, familial roots, and understanding one's strengths/gifts from Creator was emphasized to strengthen community cohesiveness and to promote acceptance. The notion of having a good mind in relationships with others and with nature, was also frequently emphasized as an effective strategy to support a healthier collective.

One storyteller's account illustrated her non-Indigenous positionality, which was characterized by feelings of hesitancy and inefficacy to engage in culturally safe manners with the Indigenous community, for the cultural involvement and development of their children.

> "I'm also a non-Indigenous, Scottish, parent of Indigenous children. In relation to who my children are, they are Mohawk, by adoption, they are Innu by blood. So, moving to territory, I try to get involved with as much as I can without overstepping, I guess is the word because obviously I don't want to offend anybody or make anybody think that I'm pushing something that I know nothing about or anything like that. Just trying to expose culture to the kids, the best that I can. Their dad works so many long hours that it's up to me to make sure that they're getting all that. And at the young ages that they are right now, I know, is the best time for them to absorb as much as possible" (Samantha, personal communication, October 24, 2023).

Additional common interpretations within the story data indicating one's identity(ies) were in relation to:

- Family and/or community histories
- Intergenerational traumas
- Stressors (such as daily stress)
- Community member divides/mistrust
- Colonization/colonial harms (of Indigenous Peoples/Wáhta'ronon)
- Internal unresolved emotions
- Lifetime milestones
- Community principles and culture/language

2 - Sources of Child and Family Health and Wellness in the Community

The Storytelling research evidenced the health and wellness experiences that influence the conceptualizations and practices supporting child and family health in Wáhta'. In this phase of the Storywork, sources of holistic wellness and health promoting practices were shared. The reported teachings included the value in leading one's health and wellness journey with an open heart to drive healing. The value in leading by one's spirit, along with the importance of maintaining balance to support holistic emotional, mental, spiritual, and physical health was highlighted.

> "So, what health means to me, the most important for me is the heart, and for me the heart is the spiritual. I know we talked about balance, but I always feel like the spiritual needs to be the priority and if I am open, in times when I am open to receiving, that's when I feel, and allow the receiving of the spiritual to come into my heart, that's when everything else falls into place. But the heart must be the center for myself to be healthy" (Turtle/a'nó:wara, personal communication, October 26, 2023).

Another storyteller described their conceptualizations of holistic health and wellness in the community.

> "I think in our teachings, well in our teachings as Haudenosaunee we talk about a good mind and a good heart. But when I think about the teachings of the Women's Nomination Belt it talks about that spirit. How we need to nurture the spirit in individuals. And when I go to ceremonies it's all about support and encouragement, again nurturing that spirit. Right? So, people can grow. I mean, it's one thing to have physical health, food, drink what you need, but unless we're filling up with spiritual health and taking care of that and emotional health, we're going to have a lot of trouble, you know. As people grow and

develop from children and onward. I have a strong connection to nature. The forest is one of my favorite places. Listening to the chickadees and all the other birdies are one of my favorite things to hear. I get up in the morning and open my window and listen for who's singing their song over there. Just watching, you know. So, I think it's, it's, it's really important to take a multi-layered approach to health, physical, emotional, social, mental, all of it. The Creator has given us the tools out there. If we can get outside of the four walls and enjoy the solitude that's out there, we would be healthier. Like growing your own food, we have a garden, and we help with the community garden here, and time is going to come when it's going to get harder, right? Yeah. I think unless we're growing a supportive, encouraging collective identity as a people it's going to be difficult for us" (Totah, personal communication, October 26, 2023).

Another storyteller detailed the prevalence of colonial traumas she witnessed and experienced as a child growing up in Wáhta'.

"It wasn't necessarily the physical violence of the kids coming off the bus from the reserve like my brothers would have experienced or having to leave to go to high school and live in town and be separated from family, I didn't experience that. But I did feel the trauma from that and then the Indian Agent coming in, and the anxiety that my parents would have had when they came to talk about the boys going to high school" (Turtle/a'nó:wara, personal communication, October 26, 2023).

Relationships were also mentioned as an indicator of health and wellness. In relation to the older folks in the community, their advice to longevity in life to stay healthy is to stay social.

"When COVID came, she was shut in and, we weren't allowing her to go anywhere. Even after the pandemic, we told her she shouldn't be going out. She did not do well without

> friends and family around her, and so those relationships are what I think is good for your health, praying/spirituality, your friendships, and your relationships. Which is why, she said ‘never put me in an old age home’” (Turtle/a'nó:wara, personal communication, October 26, 2023).

The predominant sentiment among the storytellers was the importance of traditional Indigenous plant-based medicines and natural healing methods.

> “The CHC’s teachings are awesome. I still have all the cedar salves and medicines that we made, and I have the elderberry syrup, which I swear by that. I stopped smoking here just recently. I did. I'm proud of that. Right. It all set us back to everything that the community has. And the importance of passing that to the kids and them knowing that there's better ways than just running to the cough syrup and popping pills and trying to make yourself feel better that way” (Storyteller, personal communication, October 24, 2023).

Mindfulness practices were highlighted as well,

> ” I think meditation and mindfulness activities are so important too. When we are getting faster and faster paced lives and the world around us, we need to figure out how to manage that so back to that mental health balance of life and learning and reflection” (Totah, personal communication, October 26, 2023).

Overall, the Storywork - meaning-making processes, illustrated the multitude of healing practices that hold significance among the community, such as the Ohén:ton Karihwatéhkwen, (Thanksgiving Address), land-based medicine walks, Storytelling ceremonies, Kanien'kéha/Mohawk language and cultural teachings, as well as the embodiment of the community-based values such as kindness, humility, patience, self-sovereignty over our children,

and self-determination of our health journeys. The cultural sources of healing and preventive approach to wellness emerged through the stories and was honoured by the storytellers as generationally protected wisdom and Knowledge that had been passed down to younger generations to practice leading a healthy life.

The storytellers emphasized the concern with Knowledge being passed to future generations to improve intergenerational health and wellness outcomes.

> "My granddaughter lives off territory, and I did make a promise to her that I would provide her with everything I know and that I would be her mentor in this way, because she is the only granddaughter I have. And I told her she has a special role and responsibilities in the next generation" (Turtle/a'nó:wara, personal communication, October 26, 2023).

The importance of Storytelling was highlighted as essential for Knowledge and development.

> "Storytelling is such a lost art and there are so many Indigenous practices that are nearly lost, but story is critical. And the contribution to comprehension for children is a very important part of early learning and development and should be an important part of the early years programming" (Rooster, personal communication, October 26, 2023).

Practicing traditional Mohawk teachings was reported as a key indicator of healthy development for Indigenous youth:

> "There is a land-based learning and skill-based programming here, in Mohawk language it means "good roots" and so we are really thinking about how we need to instill these foundational skills and value systems in the youth. So that they have those good roots and that they get that at the CHC, and then they flourish and grow, and whether they're in the

main school system or whatever, that they have acquired some strong roots here" (Toka, personal communication, October 26, 2023).

Additional storytellers echoed:

"And everybody needs to be, all programming leads, should be on the same page that culture and language should be priority because that's where we live, and this is where we are" (Turtle/a'nó:wara, personal communication, October 26, 2023).

In relation to self-sovereignty and self-determination, one storyteller shared their thoughts around raising healthy children:

"Self- sovereignty over our childcare, over child welfare is another thing. What is that right? With self-determination, what it means is to have healthy early years and healthy community itself. Because that's what we're seeking, right? With that process, is to figure out what it is that makes a healthy family, based on our family values. And how do we raise those children that are potentially in care or prevent children in care?" (Toka, personal communication, October 26, 2023).

The focus of early years intervention was identified as a significant indicator to promote health and wellness throughout the lifetime.

"The little ones are a bit more willing and hungrier for cultural Knowledge and they're easier to engage and pull in, which is important for the early foundations. In the early years, is really when you plant a seed. Teach them and plant those seeds and those values so that it doesn't matter if they stray or whatever in their interests, but they have their value set. It's been engrained" (Toka, personal communication, October 26, 2023).

The following were mentioned as additional sources of health and wellness conceptualizations as identified by the Storytellers/community research partners:

- Indigenous Community Knowledge - Haudenosaunee/Mohawk Ways of Knowing, Being and Doing
- Spirituality (Indigenous roots)
- Christianity
- Mohawk (acceptance of Indigenous identity as process)
- Growth/improvement due to being in community (Wáhta' Mohawk Territory)
- Resistance to western-centred health care modalities/systems/medicines
- Parent/family supports over life course
- Water/Plant-based medicines/traditional healing practices/community garden/calendar of moons cycle/local food-sovereignty practices/learning opportunities to connect with others
- Mindfulness/gratitude practices
- Flexible program delivery/approaches

Through iterative collective Storywork, the storytellers provided clear recommendations to leverage territorial, cultural, and collective strengths within Wáhta' to address ongoing barriers experienced by children and families, and to better inform future health and wellness opportunities within Wáhta' Mohawk Territory.

3 - ***Wáhta' Community Strengths, Barriers, and Opportunities for Health***

The following were regarded as Wáhta' Mohawk community-specific strengths to promote health and wellness:

- Traditional Mohawk/Kanien'kéha and traditional Indigenous Knowledge in Wáhta'
- 3-5 generations of Mohawk women in Wáhta' (sources of strength/Mohawk Knowledge)
- Dedication from staff in Wáhta' and at CHC to provide culturally- rooted programs

- Fluid, flexible program delivery/approaches (holistic approach to learning from younger ones in program)

A strengths-based approach to understanding Indigenous Peoples' health and wellness is integral to enable Indigenous-led Knowledge translation and to impact positive changes within the collective populace. The storytellers highlighted the immense strengths rooted in the land and community of Wáhta'. The data recounted the generations that have preserved Indigenous Knowledge and memory through Storytelling tradition, and the Knowledge stewardship has been sustained by the community of multiple generations of Mohawk Elders.

One storyteller reported, "I feel honoured to be a descendant of my mother's line here, three, four, or five generations of Mohawks that we know of, and my father the same. So, I feel very strong in the Mohawk. The ancestors that are with me, I feel the strength" (Turtle/a'nó:wara, personal communication, October 26, 2023).

Another described the community strengths that are embedded in the Indigenous Ways of Being, and the responsibilities of those who engage with the Indigenous-community systems.

> "They do need to know that when you work for an Indigenous community, you are working for that Indigenous community, not for your funders, not for your program plans, not for your stats. You're working for the community. And so, what does that mean when you decide to take on employment with an Indigenous community? I would hope that you recognize that we have Indigenous Ways of Being here. We did have sharing circles and we've talked about getting together to continue that good work, but when you are staff here, you are equally part of the responsibility to community as community members are" (Toka, personal communication, October 26, 2023).

The storytellers also recalled significant strengths, as evidenced in the staff's dedication to provide cultural teachings in the educational programming at the CHC in Wáhta' despite continuous challenges to relay the differences in Worldviews to the district board of education (off-reserve/off-territory):

> "When I sit in a circle with the district school board, I'm not being heard, they're not hearing what we're saying, which is that we just inherently have different Ways of Knowing and Doing and Being. And they are making it really exhausting to try to ask people to really hear us or see what it is we're saying, because they don't. It is okay to have different Worldviews, but can it be respected, where they take the time to hear what it is we're seeing and what we're saying and recognize that there's different ways? We just have a different way of thinking… so I prioritize teaching what respect is" (Toka, personal communication, October 26, 2023).

The importance of a sensible identity for child wellbeing and development was recounted by another storyteller.

> "What I had and or didn't have growing up in the public school system was someone to look up to. As a sense of like oh that is our Elder or that is our Auntie, who is a strong woman, who's founded in her teachings and her knowing of identity. I didn't have that, so at least the kids here are surrounded by their people. If they come out to community, we host socials, and the community is helping them maintain their identity because they know who their people are to look up to and who they can go to for Knowledge" (Toka, personal communication, October 26, 2023).

The strength in adapting fluid and flexible community-based approaches to educating children and youth to promote healthy communities was described by a storyteller who has transitioned their children to the home-schooling system.

> "It's trying to find a way to carve out trusting your inner self as a child, into the system, or an alternative system. I think that's important. It feels like, in the public education system, if the child doesn't fit into that box, well, there's something wrong with them. You need to address that. Right? It's not fluid. I don't like it. And for reference, if anyone does choose to homeschool their children, they do test for admission to college or university. And a lot of good colleges and universities will often prefer to take home schooled children because of how they think. I don't think a lot of people know that. That's why I'm not concerned. You could even do high school and home school as they develop more skills as they get older" (Rooster, personal communication, October 24, 2023).

Another storyteller described their children's sources of exposure to Indigenous cultural programming on territory, as their off-territory school's educational offerings are infrequent.

> "My three children attend programming in Wáhta'. They live here on Territory, attend school off Territory and attend cultural programming on Territory. They rarely receive cultural learning at their school, rarely to none. Currently" (Toka, personal communication, October 26, 2023).

The story data detailed the current early learning and youth offerings in the mainstream, off-reserve educational systems were lacking in their representation of Indigenous Ways of Knowing, Being and Doing. The cultural foundations to inform healthy, balanced communities, that generations of Indigenous communities have fought to preserve to sustain our health and

wellness, are most effective when introduced in a child's early years. The stories also illuminated the CHC's specialized strengths to leverage renewed educational and cultural trajectories to continue to support the children and families in Wáhta'. The recommendations in the stories centralize the importance of Indigenous communities actioning the right to self-determination. By serving the community interests, the barriers to community-based program delivery can more adequately be addressed.

> "We really need to be serving community first, rather than serving which area your program says, or in siloes, but get creative within that program directive, by attending to the budget to meet community needs" (Totah, personal communication, October 26, 2023).

The following are the mentioned Wáhta' community-specific barriers to health and wellness, as identified by the storytellers/community research partners:

- Isolated Territory
- Local attendance/engagement at local ceremony/programs
- Age barriers regarding community-led events
- Government determining access to participate, based on Indigenous identity
- Colonial harms/lies taught within educational systems
- Schooling off territory (Removal/displacement of children from home community to attend Indian Residential Schools in the past & present-day school systems)
- Separation from family for schooling ages

A barrier to health and wellness for Indigenous Peoples, exists in in the emotional suppression from generations of harm from colonial interferences in the traditional community (Ross, 2014). One storyteller referenced their avoidance to recall lived experiences and share

traditional Indigenous Knowledges openly. In relation to speaking one's traditional Indigenous language, at the study sharing circle.

> "A lot of the Elders just don't want to speak of things, and understandably enough. And it's just respected that that's just not what they want to put forward. I know there are a few Elders that speak fluently, but again, don't want to take themselves back to those times, emotionally and mentally" (Storyteller, personal communication, October 24, 2023).

The challenges with maintaining a family and career in an isolated region, such as Wáhta', was also an evident challenge for the storytellers.

> "Wáhta' is an awkward place to live though, as far as maintaining a career and all that because you have to travel so far and if something were to happen, in an emergency, to one of the children I would not be able to leave work in the city and quickly return to Wáhta'" (Storyteller, personal communication, October 24, 2023).

However, the sharing circle energy was grounded throughout the Storytelling sessions by centering on Indigenous Knowledge that had been shared, to inform collective responsibilities to support children's healthy development.

> "Now I always come back to our teachings of good mind and good heart in all our relations and when it comes to the children, I always go back to wherever the phrase came from, they're gifts from the Creator, and they need to be treated like gifts from the Creator, and it's all of our responsibilities to make sure to support them and encourage them. I hear what you're saying about the systems that have plans on how to educate our children. As you were saying there before, it is about the values that come with who we are as people and

> what human beings need in support, is encouragement and love, to grow" (Totah, personal communication, October 26, 2023).

The following are the local opportunities and specifics for health and wellness development, as identified by the storytellers/community research partners:

- Access to Services – i.e. Autism Spectrum Disorder & adaptive support services (for early years ages) in community (currently outsourced developmental disability services)
- Schooling on territory (formal & informal/home school)
- Access to Language (Kanien'kéha)/land/culture
- Concern for ensuring the transfer of knowledge to future generations/Seven Generations Principle/Knowledge transfer
- Develop local food sources/local cooking socials
- Learning across generations/Reciprocity
- Storytelling
- Leadership training/Confidence training
- Mindfulness exercises
- Truth and Reconciliation programming for non-Indigenous allies/family member engagement
- Building connections through programs (male-centred, family-centred, intergenerational)

One storyteller described their experience with accessing adequate services for their grandchild in their early years within Wáhta' child and family services.

> "I have 3 grandchildren, one who falls into the early years age group but is not able to attend programming here at CHC because they go to specialized services and are bussed every day because they have autism and sadly because we don't have those supports

> here. They're doing really well in terms of developing there so I'm conflicted, but I would really love to have them here" (Turtle/a'nó:wara, personal communication, October 26, 2023).

As described, the ongoing separation of the child from the family and community to attend specific educational opportunities to support the child's needs that are currently not offered in the community is an identifiable barrier. The outsourcing of specialized services is an apparent access issue within the programming offered at the CHC and is a communicated area to consider opportunities for, with in-community supports. The CHC leadership in Wáhta' are recommended to gather additional information regarding the children in the community who could benefit from the specialized supports, to offer in the community.

Child and family health supports were often characterized by the storytellers as being defined by the spirituality and the adaptive approaches to raising children. One storyteller reported:

> "All children and youth need prayer. Because I mean certainly, right now they're facing a lot of situations and whether it's in Wáhta' community or outside community, we need to pray for the child and the parents to raise them in the best way that they can, and to learn, and be open to new ways that if they're not thriving" (Totah, personal communication, October 26, 2023).

For example, the importance of practical, land-based, Indigenous methods of Knowledge exchange was cited often for improved child health and wellness.

> "'I am a firm believer of lessons outdoors and learning by doing. Because you talked a lot at the beginning of this study, in the ethics process, it just went over my head. But for the record, ethics, Indigenous ethics, is having this Storytelling discussion. I'm going to

remember all about you. I'm going to remember about you. I'm going to remember about each one of you. Because I'm involved in this discussion, right, I'm involved in the activity. And it goes back to the four walls, and it doesn't always have to happen in a classroom. Take that classroom outside if the date permits and everybody's ready to go" (Totah, personal communication, October 26, 2023).

Amid the diversity of voices and experiences shared in the stories, similar meanings and feelings pertaining to child and family health emerged. The growth opportunities to improve health and wellness in Wáhta' described throughout the stories included:

- "Encourage the family as a whole to participate in events, I find a lot of the mothers and the children coming out to a lot of the programming" (Samantha, personal communication, October 24, 2023).
- "Offer mentorship for youth, to have those older, Elders, or if they're teenagers, whoever they look up to, to teach them, because it's not just one way of teaching them. In all aspects, Creation and you know, they would get a whole bunch of life lessons" (Samantha, personal communication, October 24, 2023).
- "I think about this as my children get older, we need a focus on healthy leadership and healthy maintenance of yourself - self-growth as a human to be able to lead people and lead programs and groups, leadership in general" (Samantha, personal communication, October 24, 2023).
- "What mothers really need is more wellness, more self-care. So even though this program is the Parent-Tot, what I'm hearing and seeing is mothers really are very depleted, and they just need less time commitment and more access to wellness" (Toka, personal communication, October 26, 2023).

Discussion

Matrilineal Wáhta' Mohawk Tradition

In congruence with Indigenous feminist thought described in Chapter 3, the participating storytellers disclosed their identities and genders and all participants identified as cis-gendered women, and spoke in relation to their roles within their families. They also collectively described experiences throughout their life courses in relation to the natural environment and healing. Specifically, the reported identities of the storytellers reflected the traditional matrilineal norms of Wáhta' Mohawks and the cultural practices around family governance, in the community, that have been challenged by colonial gender structures, for generations. As described by Katsistohkwi:io Jacco, the traditional matrilineal norms of the Wáhta Mohawks, including their family governance structures, have been significantly challenged by colonial gender structures over generations (2021). These colonial influences have disrupted ancestral territories, kinship relations, and governance systems, leading to a reconfiguration of gender roles and family dynamics within the community. A scholarly analysis by Jacco examines how colonial-imposed structures and policies, such as the Indian Act, have impacted Onkwehón:we (Indigenous Peoples) women's roles in cultural regeneration and governance (2021). The study highlights the forced removal and disconnection from ancestral territories and kinship relations, which have particularly affected women's bodily autonomy and their roles in cultural practices. This disruption has led to challenges in reclaiming traditional governance structures and cultural practices. Therefore, the promotion of Storytelling research reflects the traditional leadership roles of women in the Mohawk community as evidenced by the participants and study methods.

Additionally, Hill (2017) discusses the matrilineal organization and gender roles within the Haudenosaunee Confederacy, of which the Wáhta' Mohawks are a part. The study

emphasizes the central role of women in political and social stability, including their authority in family governance and cultural practices (Hill, 2017). The research underscores how colonial influences have impacted these traditional roles, leading to shifts in family governance and cultural practices, that has impacted the long-term health dynamics among children and families. As a result of my research study bringing together the parents/guardians of the children involved in the early years programming, the representation of women that identified as mothers in the community emerged. This activated the traditional, matrilineal decision-making structure, through the Storytelling methods, and fostered a sense of unity among the women participants in Wáhta' Mohawk Territory. In this instance, the storytelling research activities facilitated the revitalization of traditional gender norms in Wáhta'. Through storytelling, which reflected distinct cultural lenses and roles as women in the community, the storytellers analyzed the data. The matrilineal governing structure of the storytelling circles shaped the Storywork process, drawing on the voices of Indigenous mothers and their reported intersectional identities and lived experiences." To reiterate, intersectionality refers to the focus on the connections of race and gender, to highlight the need to consider multiple sources of identity when examining the construction of the social sphere (Crenshaw, 2005). The representation of the participating mothers, at all life stages, with varied cultural backgrounds contributes remarkable perspectives to the child and family health research study presented here. "The perspectives of participating mothers provide critical insights into addressing gaps in research and practice related to culturally informed engagement with Indigenous children and families. This study challenges dominant knowledge systems and societal structures that perpetuate racism, gendered violence, and social exclusion—issues that are deeply connected to the ongoing crisis of Missing and Murdered Indigenous Women and Girls (MMIWG). By centering Indigenous self-determination,

it contributes to educating health sciences institutions on Indigenous research methodologies that align with community priorities. Furthermore, Indigenous-led child health initiatives emphasize the role of community-based, land-based, and culturally rooted health promotion strategies in fostering resilience and well-being among Indigenous youth (Greenwood et al., 2018; Jack et al., 2021). The persistent misrepresentation of traditional gender roles by non-Indigenous researchers has led to inadequate recognition of diverse Indigenous knowledge systems, ultimately hindering efforts to support Indigenous health and well-being in Canada (TRC, 2015; Smith, 2012; Walter & Andersen, 2013; National Inquiry into MMIWG, 2019). The stories exemplify the fluidity of experiences among residents in Wáhta', as well as the common barriers impacting community-based health among children and families. The barriers that were identified enriched the discourse in the sharing circles, as the storytellers collectively recognized solutions to several of the identified challenges. In relation, Gregory Cajete's *Native Science: Natural Laws of Interdependence* (2000) offers a comprehensive exploration of Indigenous perspectives on science, emphasizing the interconnectedness of all living beings, including children and families, and the natural world. Cajete discusses how Indigenous peoples have a "lived and creative relationship with the natural world" and a heightened "awareness of the subtle qualities of a place" (Cajete, 2000). He contrasts Indigenous science with Western science, noting that the former often includes spirituality and emphasizes relationships between species (Cajete, 2000). Through the Storyteller's own accounts of these relations and through their own descriptions in the data, conveyed in-depth, nuanced reflections of the identified community strengths and fostered unity to share child and family related, lived experiences. The Storytellers also identified the most desirable healing directions to consolidate into the Wáhta' community research records. The forum of in-person meetings, at a culturally safe, central location, during

regularly scheduled programming in Wáhta' enabled the parents/guardians to adapt to the competing demands of their roles in life, and accessibly contribute to informing recommendations at the CHC.

Throughout the process of identifying the community health barriers, the storytellers embraced the process of self-determining collective solutions, to be carried out in the future cultural and healing-centred programming in Wáhta'. In a review in the *International Journal for Equity in Health* discusses best practices to support the self-determination of Indigenous Community-Controlled Organizations (ICCOs) in health research. The paper identifies three key strategies (Erb & Stelkia, 2023):

1. Creating capacity-bridging initiatives to overcome funding barriers.
2. Building relational research relationships with ICCOs to ensure culturally appropriate and effective health interventions.
3. Establishing a network of partnerships and collaborations to support ICCO self-determination in health research.

My study with Wáhta' Mohawks reflected these practices to support the right to self-determination. For example, the study acknowledged the relationships and networks in the community by creating the study as an initiative for gathering the minds of generations of community members to promote the strength and wisdom shared in the Storytelling research by the participating mothers. With the advent of the research partnership, the study catalyzed new connections amongst the storytellers that contributed to a renewed energy among the storytellers. The themes inform the value in identity development, clarify opportunities to address in relation to community health barriers and honour community strengths for the benefit of current and future generations of children.

Indigenous-led Research Partnerships

My research study underscores the need to prioritize research environments, that are adequately resourced to be led by Indigenous Peoples, that represent diverse Ways of Knowing, Being and Doing to support Indigenous child and family health. Moreover, through the promotion of Indigenous self-determining research relationships, policymakers and practitioners within the health and education systems can exemplify their improved understandings and accountabilities to furthering reconciliation in Canada. The following are three general institutional recommendations, derived from the literature and have been reflected by the storytellers' descriptions of experiences within Canada's health and educational institutions. The corresponding community-specific indicators of success, provide community-centred information to measure the utility of the recommended changes, and will be areas for inquiry in future iterations of my research with Wáhta' Mohawks and institutional partnerships (Table 1).

Table 1: General institutional recommendations and indicators of success

Recommendation	Indicators of Success	Community-specific Indicators
Prioritize research and funding to support representation of Indigenous Knowledges.	•Inclusive learning and research environments representative of First Nations, Metis, and Inuit (FNMI) teachings. •Increased representation among FNMI research principles, protocols, and partnerships. •Increase community-centered approaches that integrate Indigenous epistemologies and Indigenous Research Paradigms (IRPs) as they are more relevant to the Indigenous community-specific realities (Wilson,2008).	•Evaluating personal transformation(s) and impact(s) of IRP. •Evaluating the study process. •Assess impacts of stories for storytellers and listeners/knowledge users.
Support self-determination of Indigenous communities through collaboration and reciprocal relationship building.	•Increase interdisciplinary engagement across Queen's University to support Indigenous community self-determination. •Expand opportunities for experiential Indigenous health programming.	•Evaluation with Indigenous community research partners to support self-determination and more positive program outcomes (Firestone et al., 2020).
Better inform policy innovations and increase understanding through educating future health professionals in Indigenous health worldviews.	•Access to IKT educational resources to support institutional members as they absorb Indigenous health concepts into their accountabilities (TRC, 2015) •Self-reflection of internal learnings, and reporting measures of change in behaviours, attitudes, and skills regarding Indigenous Health.	•Evaluation praxis framed within considerations for sovereignty, self-determination, and healing versus the mainstream evaluation discourse of difference, competency, and issues of access (Cavino, 2013).

As Table 1 illustrates, the first recommendation identifies the need to prioritize research and funding to increase the representation of Indigenous Knowledge systems in educational and health environments, to preserve cultural identities among children and families. Promoting inclusive representation of Indigenous Peoples encourages community resilience through

addressing systemic inequities more effectively with community-centred paradigms. As highlighted in the storytelling circle theme of opportunities for improving child and family health include leadership succession planning to uphold traditional community roles and ensure the transfer of knowledge between generations (Storyteller, personal communication, October 24, 2023). This is an example of prioritizing an Indigenous Knowledge system to increase representation and support the right to self-determination of Indigenous rights-holders, which advances health, overall. Further, leadership practices and skills-based programs were highlighted as important opportunities to encourage identity development and self-awareness of Indigeneity in the stories' themes, as identified by the participating mothers, to reinforce cultural continuity and to prepare future leaders in navigating both traditional and modern challenges in educational and health services in Canada. The theme from the stories that reported community strengths and contributors to child and family health, highlights the strength of maintaining the community members' responsibilities to teach traditional ways of life, particularly land-based knowledge, were frequently mentioned as vital elements for strengthening community connections to the land and ensuring sustainability practices are carried forward (Turtle/a'nó:wara, personal communication, October 26, 2023). However, as the theme of areas to improve elucidated, the lack of culturally relevant curricula in schools, especially for Wáhta' youth that attend off-territory public institutions, creates a significant gap in education that risks eroding Indigenous Knowledge and values (Toka, personal communication, October 26, 2023). Therefore, prioritizing funding for culturally and regionally relevant programming and community-specific initiatives that investigate and evaluate Indigenous Knowledge systems in addressing child and family health, will empower, in this case, Wáhta' Mohawks, to address urgent challenges. Overall, the recommendations challenge mainstream power structures to

foster pride among the Indigenous community, to uphold the right to self-determination, and encourage intergenerational knowledge sharing.

Further to Table 1, the second recommendation advises institutions, such as Queen's University, to uphold the right to self-determination in health research with Indigenous Peoples, through reciprocal relationship-building, as outlined with this research partnership. My research approach has proven this recommendation is fundamental to strengthening Indigenous communities and advancing healing amongst the collective children and families. The thematic analyses about health promoting practices in the community emphasized the importance of revitalizing traditional healing practices such as Storytelling, land-based learning, and intergenerational knowledge sharing was frequently cited by the storytellers (Rooster, personal communication, October 26, 2023). As reflected further in the mothers' stories and resultant themes, practicing these healing practices are central to identity formation for Indigenous Peoples and community cohesion. For example, Elders play a pivotal role in transmitting stories that require patience and reflection, teaching children to listen, learn, and internalize lessons that may reveal their significance over time (Toka, personal communication, October 26, 2023). Such stories, tied deeply to land and community, serve as anchors for understanding who they are and how to care for themselves and others. Reciprocal relationship-building ensures these teachings are not lost but actively integrated into community child and family supports and programs. By prioritizing self-determination and providing resources to sustain these cultural practices, with iterative community-led evaluations of the culturally informed initiatives, Indigenous communities can reclaim and strengthen their ways of knowing, fostering a collective sense of purpose to sustain the well-being of current and future generations.

Table 1 highlights the recommendation to institutions to better inform policy through enhanced teaching and learning related to Indigenous Ways of Knowing Being and Doing. This recommendation links to the themes of barriers reported in the storytelling circles and aims to address the systemic inequities that impact the wellness of Indigenous Peoples.

For example, one storyteller recalls the value of the Thanksgiving Address, in Mohawk, as a teaching that represents Indigenous Knowledge to maintaining wellness, that is not a teaching or learning practice in public schools.

> "I get a little bit frustrated if I sit in a circle with the district school board. I'm not being heard, they are not hearing what we're saying, which is that we just inherently have different ways of knowing and learning and being. Our identity and the ways of knowing come from so many areas including being on the land and being with community. For example with the Ohén:ton Karihwatéhkwen teaching/the Thanksgiving address and what part of address, really calls to you? All of it excites me, even the winds. So, I get really excited in a good storm, I must go outside to get energized. Me, it fuels me up and brings my energy up" (Toka, personal communication, October 26, 2023).

Moreover, the recommendation to enhance teaching and learning through Indigenous Knowledge representation, is underscored by another storyteller who emphasized the importance of teaching the children healthy habits in the community. One example involved the lesson a young boy received by chopping wood for an Elder. Through this essential and meaningful act, the boy learned multiple lessons: the importance of caring for Elders, the value of hard work, and the benefits of physical activity. The experience also provided an opportunity to connect with nature and develop practical knowledge about the wood he was cutting—its hardness, its uses, and how to identify quality wood. Such lessons, though seemingly small, are deeply impactful,

nurturing a sense of responsibility, resilience, and connection to the land and community (Toka, personal communication, October 26, 2023). As articulated frequently by the storytellers, integrating Indigenous Knowledges and culturally relevant educational and health policy into practice development, ensures that policies reflect and respect Indigenous values, principles, traditions, and lived experiences. Teaching and learning initiatives should prioritize land-based practices, community-driven approaches, and intergenerational knowledge sharing to strengthen connections to culture and identity (Chickadee, personal communication, October 26, 2023). Table 1 highlights three recommendations for institutions to prioritize resources to address Indigenous-informed solutions, to partner with Indigenous Peoples in a good way to produce a positive impact on the health of Indigenous children and families, while advancing research, policy and practice for all health professionals.

Overall, my dissertation supports the requirements for the Doctor of Science degree in Rehabilitation and Health Leadership and provides codified records of a unique collaborative model that demonstrates the possibilities to enhance educational and health systems through inclusive and adaptive leadership approaches in research relationships and through the revitalization of Indigenous Knowledge systems. The findings from the Storytelling research are intended to offer in-depth accounts to contribute to the existing research and to inform future directions to increase healing in the partnering community. Genuine reconciliation requires self-reflection, to address one's own gaps in knowledge, and in relation to Indigenous representation within health and educational systems. The anticipated effects of my study include a shift in public perceptions of anti-Indigenous racism, and an increase in accessible, culturally safer programming and services by care providers in relations with Indigenous Peoples in Canada. Improving research relationships through Indigenous-led research processes contributes to the

overall national efforts for reconciliation and to the decolonization journey across health and educational systems in Canada. Although the findings are attributable to the community storytellers in the context of this study, the common themes, and experiences echo generations of Indigenous Knowledge, that demonstrate that the most vital medicines reside within culturally based, holistic knowledge systems that support Indigenous Peoples' health and wellness.

Community Benefit

As my research focuses on the community benefit(s) of the research, encouraging Indigenous community engagement through relational accountability, addresses the complex and underlying explanations as to why Indigenous Peoples are generally disinclined to engage with the mainstream health and social systems. Through the intentional inclusion of Indigenous and non-Indigenous parents/guardians who reside in Wáhta' to participate as research partners offers broadened perspectives on child and family health in the community and ensures the evidence informs findings that will serve holistic priorities. Further, the Storytelling research reflects Indigenous-community engagement, as it is a practice within Indigenous cultures that supports communities, validates epistemologies, communicates experiences of Indigenous Peoples, fosters knowledge sharing, and relationship- building (Iseke, 2013). Thus, by leveraging the community-identified strengths, results in community-determined solutions for future generations. The recommendations from the research honour the guidance of the research partners, including community Elders and Knowledge Keepers. This model promotes the transfer of knowledge to the next generation and is rooted within Indigenous knowledge systems, that has sustained Indigenous community health and social fabric for many millennia (Gallagher, 2019).

Study Outcomes

The study partners within Wáhta' leadership, the CHC leads, the steering CAC and I, worked to foster a research partnership that challenged the standard western-oriented approach to health sciences. The goal was to conduct Indigenous-led Storytelling research within the Indigenous community, to better understand the community priorities for child and family health. The foundational anchors of the study process are represented by the IRP, a model rooted in an Indigenous Knowledge system and is applied within the regional contexts and current realities, which reinforces the study's community-centredness and relevance. The IRP promotes Indigenous Storytelling research methods and collaborative data analyses via Storywork. The outputs of these processes represent the most suitable framing of the Knowledge that is encoded in and generated from the Storytelling. This is referred to as an "experiential distilling of wisdom— a transfer from wisdom-keepers to new generations" (NCCIH, 2021). The dynamic nuances revealed throughout the Storywork illuminated several important themes that provide in-depth accounts of child and family educational and health priorities. The meanings derived from the Storywork enables the space for self-reflection and emotional reconnection to begin to find the language to process and reconcile those feelings that have been reinforced by the generations of trauma, secrecy, and disempowerment of Indigenous children and families (Ross, 2014). Therefore, the Storytelling sharing circles served to hold space for personal and community-centred reflections, knowledge sharing and stimulated connections among the storytellers and I, which increased the depth of understanding revealed overall in the stories. The recommendations from the data will contribute to reconciling health in Wáhta' by addressing the gaps in research and promoting the solutions within the early ages programming for children and families. Policies and programs at the CHC are reviewed regularly, and my study is serving to better align the study's recommendations with the CHC's programming which aims to enhance child and

youth health. Based on the final reports, which have been shared with the directors of educational programming, the cultural advisor, and is available to community members, the Centre will implement culturally grounded health initiatives that prioritize land-based learning, traditional knowledge transfer, and intergenerational mentorship. These policy changes will integrate culturally relevant curricula, expand youth engagement in traditional practices, and create safe, inclusive spaces for healing and well-being. Guided by the Principle of Reciprocity, the Centre will maintain ongoing collaboration with research partners and invite additional community leaders to conduct similar studies with Storytelling, to ensure that these initiatives continue evolving to meet the community's needs, fostering sustained partnerships and accountability in supporting the health of future generations.

Study Limitations and Future Recommendations

My study was marginally limited by the time-bound procedures, to ensure a timely defense of the research doctorate at Queen's University. The community relationship-building process could have benefited from additional visits to deepen awareness and engagement of other departments to participate in the study. However, the development of the partnership with the CHC, laid a strong foundation of trust, allowing progress to continue. The sample size (n=7) and composition enabled the sense of psychological safety among the storytellers to develop as the sharing circles progressed, and resulted in the occurrence of intimate discussions that will more accurately inform the health and wellness advances among the population. The participants in the sample size spanned all adult life stages and reported experiences of women, their children, and families in the community. Therefore, the storytellers assumed matrilineal roles and exercised this power throughout the study, which reflects the traditional community

governance structure among Wáhta' Mohawks, an unintended but remarkable component of the study's strengths.

The research partners also identified opportunities to host additional iterations of the Storytelling research, as the community cyclically renews its programs and services. Additional Storytelling research activities are envisioned to serve as future check-in points to inform the ongoing implementation and utility testing phases resulting from the study's recommendations. Therefore, through sustaining relationships, the evaluation of the study will maintain community reforms with the community-based partners. By reporting on how the partners assess the transformative impacts of the sharing circle research for the storytellers and listeners, is also an identifiable priority for future discussions.

The potential future iterations of the Storytelling research would not only serve to evaluate the evidence-based recommendations emerging from this study but are opportunities to meet with additional community departments that contribute to broader community health and wellness. Additional suggestions stemming from the research study included hosting research with representatives of the community health, membership, and housing departments to increase alignment with broader developments in the Nation. This approach tends towards longer-term engagement, maintains community self-determination and results in more positive program outcomes (Firestone et al., 2020). It also strengthens the research reliability due to increased participation in the Storytelling methods to increase the evidence-base informing Indigenous-led child and family health research.

By conducting my research with the guidance of an IRP honours, respects, articulates, and manifests the research tools, questions, and means through Indigenous worldviews. The features of my study's IRP provides information into the future, to support researchers and health

organizations, on effective processes to positively relationship-build with an Indigenous community. Furthermore, the Storywork process promotes health through research, as the method is "traditionally rooted, helps with identity, community connectedness, self-esteem, family connectedness, culture, language, and keeping Traditional Knowledge alive" (Mashford-Pringle, 2016, p. 99). Through the ceremony of Storytelling, the study created opportunities for community engagement beyond those available with traditional, western research approaches (Lafreniere and Cox, 2012). Therefore, the data collected throughout the research serves to broaden the scope of evidence that can be leveraged in future studies to challenge the major political discourse within the evidence-based practice movement (Denzin, 2009). As a result, my research with Wáhta' Mohawks, is grounded in the Storytelling context and cannot be separated or generalized from the context. However, the specificity does not limit the value of the research to a single time or place, because the transformative effect of the stories can stay with the listeners and continue the challenges of transformation posed in the stories (Iseke, 2013). As a result, Storytelling can be healing to the teller, but the listener as well, as "stories about real events first grab the heart, then the heart sticks them in the mind" (Ross, 2014).

6

Health Leadership: Solidarity and Reconciliation

A prominent takeaway from my research highlights how all researchers and health leaders have the duty to reflect on the history of Canada's relations with Indigenous Peoples, to understand the inadequate approaches to developing healthy children and families through Euro-centric research processes. Therefore, my research centres a unanimous call to action to stand in genuine and authentic solidarity with Indigenous Peoples and Nations in "our ancestral, unceded and occupied Homelands, by first learning of what is and has been done in your name as a citizen, permanent resident, refugee, or immigrant to Canada" (Dupuis-Rossi, Hellson & Reynolds, 2020), and to stand in solidarity while holding the complexity of overwhelming emotions of being "repulsed, angry and heartbroken in the face of human atrocity while simultaneously realizing that you are the direct beneficiary of it (Dupuis-Rossi, Hellson & Reynolds, 2020).

As examined throughout this dissertation, the paternalistic medical research practices of the Canadian government, as well as political and legal structures of inequality and oppression, have resulted in severe harm to Indigenous Peoples (Indigenous Health RCPSC, 2019). The Euro-centric rigid, social structure that Canada was founded in, reproduces and maintains inquality in Canada. This sentiment reinforces the experiences described in my study, that identify the Canadian social structure as a foreign imposition that has exploited traditonal Indigenous lifestyles and community traditions to maintaining health and wellness. As shared in the stories, the anti-Indigenous racism, accounts of sexism and gender norms that reinforce colonial ideals clearly evidence the oppressive realities endured within the population, through time, in Wáhta'. The marginalization of Indigenous Ways of Knowing, Being and Doing are marked by Canadian

institutions of power, as the dominant forces in the generation of knowledge and dissemination, and this power inbalance is maintained through the society's health and educational sectors.

Therefore, the importance of self-reflection is paramount to understand how one is reinforcing or complicit in the structures of oppression in Canada. To dismantle these forces, an intentional commitment to fostering transformations in health equity and in practice is critical to demonstrate solidarity with Indigenous Peoples (Nixon, 2019). Therefore, the practice of evaluating one's personal privilege(s) and power, based on one's positionality, serves to inform one's self-reflection and informs their positions in upholding oppressions towards marginalized groups, and to mobilize collective action towards improving those relations (Nixon, 2019).

As described throughout the study, transparent communications serve to magnify the challenges uniquely affecting certain groups in Canada. To address the challenges more effectively, researchers have the opportunity to enact positive relationship-building efforts with Indigenous Nations, to initiate the waves of collaborative insights and changes that can surface, as a result of collective reflection and urgency to act.

My approach to leadership throughout this study was underscored by the community-determined principles required to effectively guide equitable and positive research relationships with a partner. This was accomplished through non-traditional knowledge gathering, and was supported through empathy, insightful dialogue, that was thoughtful and Indigenous-informed, through upholding the right to self-determination.

One component of creating positively impactful research relationships, resides in understanding trauma-informed approaches, within a holistic lens to a person's health, to lead productive relationships. The awareness of the existence of widespread trauma and acknowledgement of it's sources that run deep in Canadian systems, is essential by health leaders to

foster genuine interactions and relationships with Indigenous individuals, and communities. When involved in relationship-building efforts, the researcher can foster an added sense of safety with respect to the surrounding environment and interrelational subtleties, to further promote the development of trust and positive connections (Indigenous Health RCPSC, 2019). As the relationship progresses, to formalize a study with the research procedures, the focus resides in facilitating the process where Indigenous partner(s) are enabled to determine their own choices, through active participation in controlling their journey. Additionally, if the research activities introduce strengths-based and skills-building opportunities, the partner(s) are further benefiting from the research, as it develops additional capacities to sustain growth and healing (Indigenous Health RCPSC, 2019).

For health leaders in research and practice, the historical, cultural and gender issues impeding on Indigenous Peoples' health and development opportunities in Indigenous populations are fundamental considerations. The breadth of understanding, on behalf of the researcher that is required to foster culturally-safer engagements extends beyond the current standard of education provided in health professions programs, thus through ongoing engagement with Indigenous Peoples and communities, one can continue to learn to develop unfamiliar teachings and skills to bolster innovative approaches to western-centred sciences and Indigenous Knowledges. In order to improve one's self-efficacy, one must engage in challenging conversations or operate in unfamiliar environments, to generate positive growth in understanding and engagement with members of systemically marginalized communities. To drive trauma-informed transformations in the health system, researchers must understand the intergenerational contexts to trauma-informed approaches. To accomplish this, requires dedicated attention, often beyond western-informed research, to examine the existing current practices, to provoke internal reflections pertaining to the role of the

researcher in reinforcing current practices, and active engagement with Indigenous Nations and community members to increase awareness and intercultural relationship-building.

The integreation of trauma-informed approaches requires a series of advanced, personally-developed skillsets, to expand on the leadership skills taught to learners and graduates, who are immersed in the dominant siloes of the western-centred health sciences educational systems.

As evidenced throughout this dissertation, humans and groups in society are distinctly diverse, and cannot be generalized into a monolithic entity. As a result, person-centred communication is integral to support the recognition of the uniqueness of one's experiences and presence in the world. By developing effective communication strategies with the partners, researchers can clarify their queries, and build on their understanding of the various health experiences and priorities of the partners, from a common language. The advantages to fostering interprofessional and collaborative spaces and opportunities to learn together for the increased benefit of the collective, is a promising approach to guide the necessary transformation, to uphold Indigenous-led solutions in child and family health.

As revealed throughout my study, the overall practice of self-reflexivity paired with the ability to understand one's own history, emotions and reactions is an important component to establishing positive interpersonal relationships. The stronger that one's sense of self -identity is, particularly in cultural connections to family and Indigenous communities results in increased potential to participate in meaningful interactions. As illustrated by the stories that were shared, the intergenerational traumas that persist among Indigenous populations are far-reaching and take many forms. Furthermore, the traumas persist, by way of various ailments or issues throughout an individual's lifetime. Therefore, the urgency to act with an understanding of trauma-informed and

healing centred approaches, is critical to sustain genuine, interrelational research processes and leverage the strengths of the community to proactively generate long term healing.

7

Indigenous Knowledge Translation Products

The following IKT products from the study are aimed at sustaining long-term, community-centred, health and wellness advances within the partnering and more broadly in relation to Indigenous child and family health and educational contexts. The IKT products have been developed through multiple collaborative approaches including communication with research partners via in-person Storytelling circles, and virtual exchange platforms, including email and OneNote shared electronic records to curate the findings within applicable formats for the CHC staff absorption, Wáhta' leadership records and Queen's doctoral formats. Various means of data translation were integrated through Storywork to interpret experiences through spoken stories and translated through art, to ensure uptake by the community-based research partners - the people for whom the research is ultimately meant to be of use (Jull et al., 2018). The recommendations of the research also extend to the broader academic community. The information gained from the study could help inform the creation of inclusion policies and practices in schools, as well as the development and implementation of support systems for learners and their families. For example, to inform the curriculum for practitioners working with Indigenous children in early learning and childcare programs. The IKT products include a personal anecdote to further depict the various colonial wounds that undermine Indigenous Peoples' health, as well as illustrates the vibrant strengths within Indigenous Peoples to lead solutions to address the enduring health inequities.

(Re)conciliation of Indigenous Health at Queen's Health Sciences

Academic research institutions are working in various ways to promote truth and reconciliation with Indigenous Peoples but vary in their methods and strategies to accomplish this. The following opinion piece examines the barriers to activating reconciliation at Queen's Health Sciences, in relation to its 2021 - 2026 strategic plan. I have included a personal story related to my lived experiences in learning from my ancestors, notably my great grandmother. This story I share, with permission from my Elders, to emphasize the importance of increased representation in health and educational spaces to promote the necessary funding and Indigenous-led strategies to foster improved understanding of diverse lived experiences among Queen's University's faculty, staff, students and community.

Figure 5: (Re)conciliation of Indigenous Health at Queen's Health Sciences: Infographic to encourage the (Re)conciliation of Indigenous health at Queen's Health Sciences.

(Re)conciliation of Indigenous Health at Queen's Health Sciences

Queen's University's Faculty of Health Sciences (QHS) has embarked on a new strategic plan, "Radical Collaboration for a Healthier World," initiated in 2021 until 2026, which includes guiding principles of Equity, diversity, inclusion, Indigeneity, and accessibility. While the principles have been outlined as priorities, barriers to achieving distinct goals persist, largely due to limited institutional ***funding, and limited Indigenous-led solutions through policy reform.***

Cultural safety is a lifelong process whereby a provider embraces the skill of self-reflection to advancing therapeutic encounters with First Nations, Inuit, and Métis peoples in what is now known as Canada. Iterative self-reflection is essential to understanding power differentials. The Indigenous Physicians Association of Canada also emphasizes, "a central tenet of cultural safety is that it is the patient who defines what 'safe service' means to them."

I am grateful to share the story about a woman named, Iris. She was a survivor of Indian Residential School in Sault Ste. Marie, Ontario which was operated by the Anglican Church of Canada and the Government of Canada. She was not referred to by her name, Iris Cecilia Thompson, but listed as a number 1932.999. Iris attended Shingwuak Residential School from 1932 to January 5th, 1939, where she reported having layers of her skin rubbed off with steel wool by the schoolteacher nun– specifically in areas where the skin was higher in melanin and thus the skin was brown in pigment. Of course, as her great granddaughter with the same features, to my skin, I know it's a genetic feature of our Mohawk family and could not be scathed off. Such a traumatic recount further details the behaviours that were systemically enforced inside and outside of the walls of the Residential Schools. Now, fast forward two generations to 2015, and the Canadian government released the Truth and Reconciliation Report with 94 Calls to Action, in response to the School's anti-Indigenous policies that continue to oppress Indigenous Peoples today. The residual effects present themselves in culturally-unsafe gaps in the healthcare system.

To most effectively innovate culturally-responsive health education opportunities for learners at Queen's, requires engagement and decision-making to ***shift from Queen's health sciences experts to allies with the Indigenous health knowledge experts.***

A Road to Radical Collaboration

Radical Collaboration requires principled approaches to engagement, reciprocal discussions, and gathering information through advocacy tools to gather Indigenous health experiences and stories. The stories shared in the storytelling circles are intended to inform future changes in funding and policy reform. With 1.7 million Indigenous peoples comprising the national population, health sciences curricula needs to integrate the perspectives and experiences of the fastest growing and youngest population, in order to appropriately serve these groups in the long-term.

It is critical to address the knowledge gaps because an incomplete health sciences education impacts the preparedness of our future health care professionals to adequately care for Indigenous Peoples. Actualizing reconciliation is the responsibility of every Canadian, however Queen's University occupies an extraordinary role in developing health education and practice leaders, as a site of knowledge creation and dissemination. Without immediate action, culturally unsafe experiences, re-traumatization, avoidance of and lack of trust in the educational and health care systems, and stagnant improvements for Indigenous health outcomes will persist. Therefore, increasing resources that develop Indigenous community-led partnerships to inform culturally safe, and trauma-informed educational, preventive and genuine radical collaborations will more effectively support Indigenous health outcomes that sustains Indigenous self-determination.

KARIHÉHTHA' CORTNEY CLARK
DSc RHL Candidate
Queen's University

QUEEN'S UNIVERSITY FALL/WINTER 2024

Illustrations of Indigenous Stories

Figures 6 - 11 and the corresponding descriptions, are the artistic representations of the Storywork findings, in relation to reconciling Indigenous child and family health in Wáhta' Mohawk Territory. A virtual tool was utilized to illustrate the storytellers' health conceptualizations from the reported motifs and teachings in the Storytelling research through an image generator (Canva, 2024). Through representation of the imagery reported in the stories, fortifies the community-based Knowledge and expands on the reported community-specific health enablers and sources of wellness.

Figure 6: "The Storytellers"

Figure 6 symbolizes the Indigenous research partners by their pseudonyms, in the Storytelling study. Notably, S., Chickadee, Toka, Samantha, Turtle/a'nó:wara, Totah, and Rooster, illustrated against the backdrop of the lakes, maple trees and the old cranberry marsh, the natural environment of Wáhta'.

Figure 7: "Mom and Tot"

Figure 7 represents the Indigenous research partners that are enrolled in the Early Years Program at the Cultural Healing Centre in Wáhta' Mohawk Territory. The Mohawk mother and child are wearing traditional regalia and are sitting with nature, and exploring sources of healing in Wáhta' Mohawk Territory. The described healing effects of the waters, cedar trees, maple trees and traditional healing practices through generational knowledge exchanges, were identified strengths to inclusively promote health for children and families in Wáhta'.

Figure 8: "The Environment and Resilience"

Figure 8 demonstrates the value in early years immersion of children in experiential, flexible, land-based learning environments to support healthy development. One storyteller described that children who do not connect with nature before the age of 12, are less likely as adults to connect with nature. They therefore lose out on the resilience nature provides when you are really stressed.

Figure 9: Wáhta' Mohawk Territory Health

Figure 9 portrays the interconnected elements of the land that were referenced in relation to sources of child and family health in Wáhta' Mohawk Territory. The changing colours of the leaves represent the changing seasons amid the the fall season in Wáhta', and reflects the harvest season in the community. The harvest ceremony consists of processing plants and animals from the land, and preparing medicines to sustain community wellness throughout the winter. The naturally occuring plant-based medicines in Wáhta' that were mentioned include derivatives of cedar, maple trees, numerous types berries, including cranberries, elderberries, blueberries, blackberries, the rivers and lakes, and and the various roots of plants that grow within the region.

Figure 10: "Family-centred Healing"

Figure 10 exemplifies the strengths of the educational and healing opportunities embedded in the community programming at the CHC. The stories detailed the overall benefits of learning to cultivate natural medicines with the children and family, to revitalize traditional healing practices in the community. Learning centred around food preparation, between generations, in the early years program was cited as an area to promote mentoring relations in supporting healthy children and families.

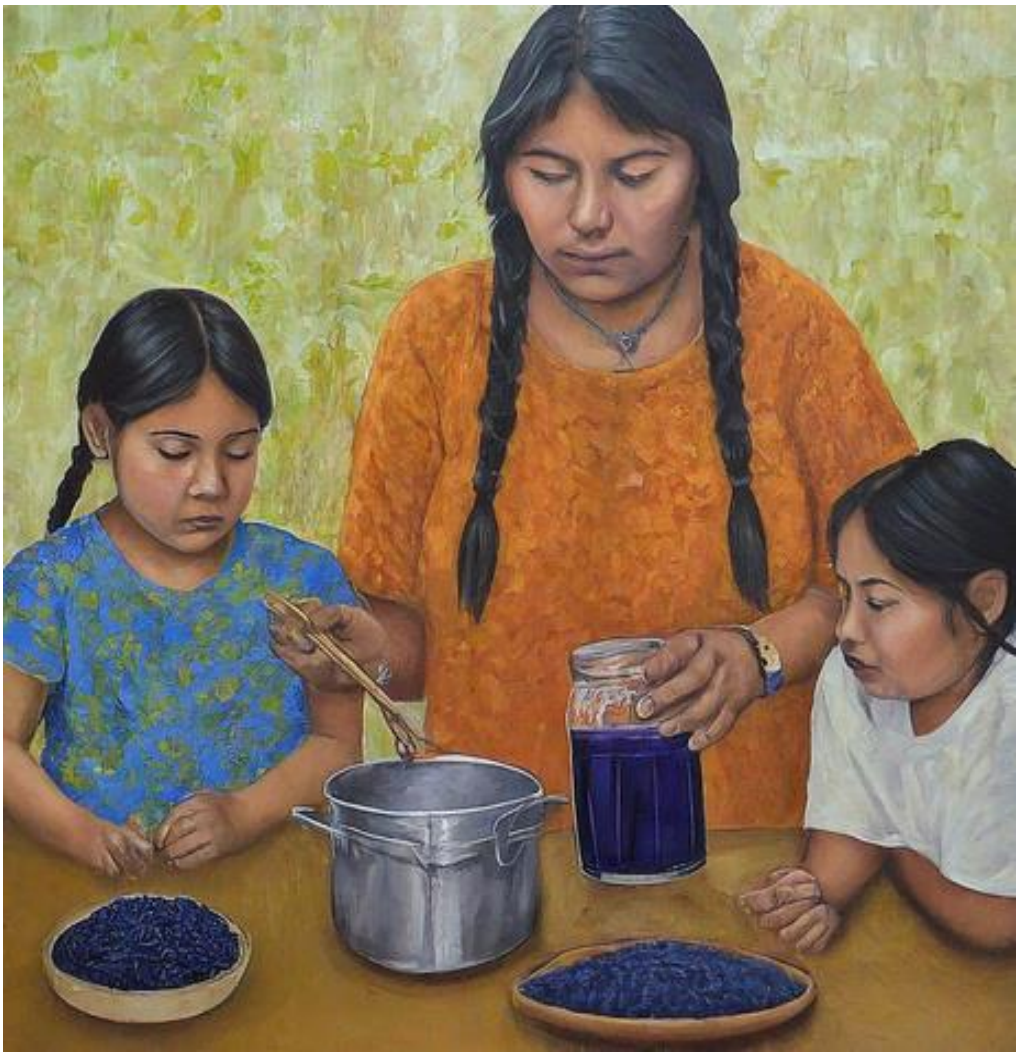


Figure 11: "The Gathering of Minds"

Figure 11 is a translation of the family-centred learning that was frequently recommended in the Storytelling research to enhance engagement with child and family programming in Wáhta' Mohawk Territory. Multiple storytellers identified as being immersed in a journey of reclaiming their Indigenous identities, within Wáhta'. The role of the CHC in supporting child and family healing processes, was an identified opportunity to revitalize the traditions of reciprocity in passsing knowledge from Elders to future generations.

8

Conclusion

Indigenous Knowledge systems represent "our cultures, our worldviews, our times, our languages, our histories, our spiritualities, and our places in the cosmos" which thereby connects our shared stories to understanding the past, present and future (Wilson, 2008). The development of a new research partnership between Indigenous community-based leadership and Queen's University research partners, offers a forum to hold space for these shared stories to inform Indigenous child and family health. Through ongoing collaboration with the Chief and Council, I led the development of a Research Agreement that upholds the right to self-determination. Through in-person and virtual correspondence, the Chief and Council informed the research priorities in cooperation with the leads at the CHC. This process of fluid collaboration was essential to produce a research agreement that honoured self-determination with the Indigenous partners, to foster collaborative, positive, and sustainable research relationships (Cavino, 2013). Although this approach entailed a comprehensive preparatory, relationship-building stage prior to engaging in the Storytelling research, the Research Agreement (inclusive of a Memorandum of Understanding, Terms of Reference with a data sharing agreement as well as community and institutional ethics agreements) supported congruency with Indigenous priorities rooted in holistic and regional contexts. My approach to the study formation reflects the cyclical structure of the research process that I conducted in partnership with the community. The research stories were shared in reference and connections to past ancestral influences, life experiences and wisdom. Through the Storywork processes, the research partners emphasised the sacred Indigenous Knowledge that served to promote healthier children and families in their experiences. As interpreted in the study's findings, solutions emerge when understanding of the

historical roots of colonialism and specifically, racism, are acknowledged as ongoing determinants of health for Indigenous Peoples. The study themes defined the anchors that inform health conceptualizations in Wáhta' Mohawk Territory, which includes references to one's identity in relation to the , the sources of child and family health and wellness, as well as Wáhta' community strengths, barriers, and opportunities for health and healing.

The community partners' identities were described in relation to traditional Indigenous-community roles, familial roles, and were reflected in one's self-identity. The community at Wáhta' Mohawk Territory referenced diverse backgrounds from several Indigenous backgrounds, as well as non-Indigenous and European identities. The nuances of the identities within the community were further characterized by the acknowledgement of complex influences that contributed to identity formation and acceptance. The influences on one's self-identity included family and/or community histories, intergenerational traumas, daily stressors, community divides, colonization, unresolved internal emotions, lifetime milestones, and community-based principles and cultures.

My study evidenced the common sources of health as reported by the community residents in Wáhta' Mohawk Territory. In theory, the community-specific values, and principles, founded in holistic approaches to maintaining balance (mind, body, emotion, spirit) were commonly cited. In practice, sources of health were derived from land based, Wáhta' Mohawk Territory- specific channels. The value in preventive health and wellness approaches was also a reported health practice. Additional sources of health and wellness were credited to community-based, collective approaches with identified measures of health including cultural connections, generational indicators, relationship statuses, social relations, and prayer. The Storywork process further revealed the roots of health in Wáhta', specifically the Haudenosaunee and Mohawk

Ways of Knowing, Being and Doing, holistic understandings of health, and additional spiritual practices. The process of Mohawk identity acceptance, internally for individuals, was widely described. Moreover, one's personal growth resulting from being in Wáhta' community was a commonly reported theme due to greater access to plant-based medicines, traditional healing practices, the community garden to support food sovereignty, and flexible healing modalities.

There was explicit resistance expressed among multiple storytellers to western-health care modalities, medicines, and health systems. The preferred methods for healing centred on family and community supports, Storytelling, mindfulness, gratitude practices and following natural cycles in relation with the land/environment. In addition, the identified Wáhta' community-specific strengths demonstrated the traditional Mohawk/Kanien'kéha Knowledge that exists among the 3-5 generations of Mohawk women in the community. The dedication from staff at the CHC to provide cultural roots in programming, based on intergenerational programming opportunities, was also celebrated as a strength to promote child and family health and wellbeing. The barriers to facilitating optimal child and family health, focused on issues of access due to the community's isolated region, and the federal government's oversight of "status Indians" via restrictive programs/funding models that limit program access. Additionally, sustaining engagement levels was an evident challenge, as children are required to attend school off territory and are separated from their family on community, for the schooling ages. The most prominent barrier to child and family health in Wáhta' was identified as the colonial harms and lies that have existed and continue to exist in educational systems currently about Indigenous Peoples.

Therefore, my research proposed several specific opportunities to further innovate health and wellness in the community, beginning in the early years of a child's life. The

recommendations to offer Mohawk language and cultural programming, as well as increased schooling opportunities on territory, and the development of local food sources were specified. The community concern for the Seven Generations knowledge transfer and family-centred programs were also mentioned, thus learning reciprocally among generations was highlighted as a priority solution to consider. The opportunity to engage in Storytelling and mindfulness exercises were highly recommended as engaging opportunities to increase overall child and family health in Wáhta'. Specifically offering adaptive support services for the children, was also mentioned as a desirable extension to the current programming to better serve the children in the community.

General recommendations to enhance health within the community population included leadership training opportunities and confidence-building trainings. Additional opportunities to build connections among the Indigenous and non-Indigenous families in the community centred around truth and reconciliation programming, and through various program structures to offer male-centred, family centred, and generational-spanning opportunities was emphasised by the storytellers.

To summarize, my study conclusions bolster health and educational recommendations to prioritize research and resources that support the diverse representations of Indigenous Knowledge systems in Canadian institutions of health and education. The Wáhta' Mohawks and Queen's University Storytelling research partnership actively promotes the right of self-determination through collaborative and reciprocal research relationships, to reconcile Indigenous child and family health holistically in the community.

Appendices

Appendix A: Study Recruitment Poster

Appendix B: Wáhta' Cultural Health and Healing (Franks, 2021)

COMMUNITY HEALTH AND CULTURAL HEALING

VISION STATEMENT: "The centre of the community where our hearts begin to beat as one".

MISSION STATEMENT: The Wahta Mohawks Cultural Healing Centre supports the individual, family and community to achieve self- awareness and empowerment. The Centre will serve as a place of knowledge and learning, and will provide opportunities for community to re-establish a sense of belonging, cultural connection, healthy living and self- discovery. The Cultural Healing Centre will become an integral component to healing within community by providing wholistic programming and access to treatment to promote and maintain balance. The purpose for our work is for the "Seventh Generation; those who are not yet born but will inherit the world".

GUIDING PRINCIPLES:

- ***Otanitenrahtsera* (compassion for others)**

We will demonstrate compassion for others and recognize that each is on their own personal journey.

- ***Kakwenienstahtshera* (respect for everyone)**

We will recognize each other's personal gifts and appreciate one another.

- ***Kanoronhkhwahtshera* (love and caring for all)**

Love is a spiritual and physical connection. Our medicine is this flow of energy when our spirits connect; this is love.

- ***Kahretsaronhtshera* (words of encouragement for all)**

Words of encouragement are not possible unless compassion and love is present. Encouragement for one another is a basic responsibility. It is when this teaching is fully understood and applied then one has a good mind.

- ***Skenen* (a state of peace)**

Words of encouragement will bring peace among us. When we experience a sense of peace we become more positive. Our positive outlook will encourage others to find their own peace.

- ***Ka'shatstenhsera* (inner strength)**

Our own personal power of well- being enables us to fulfill our responsibilities while we walk on this earth.

- We will promote belonging and acceptance for all as we continue to build a sense of community.
- Programs and services are available to all community members and citizens; those members living beyond the borders of the Territory are encouraged to participate.
- All programs and services will reflect our culture and traditions and will meet the identified needs of the community with the purpose to regain and retain our language and culture.
- Confidentiality must be adhered to in order to create a safe place of trust which is vital to the success of the Centre and the programming that occurs within.
- We support and empower our own resource people as we recognize and respect their gifts and acknowledge their help to achieve our goals.

Appendix C - Ethics Approval Correspondence

Queen's University Health Sciences & Affiliated Teaching Hospitals Research Ethics Board (HSREB)

HSREB Initial Ethics Clearance

October 18, 2023

Miss Cortney Clark
Department of Emergency Medicine
Queen's University

TRAQ #: 6039076
Department Code: EMED-386-23
Study Title: "Reconciling Indigenous Health through Storytelling with a First Nation Early Learning and Child Care Program"
Co-Investigators/Supervisor: Dr. Janet Jull
Review Type: Full Board
Date of Full Board Meeting: July 10, 2023
Date Ethics Clearance Issued: October 18, 2023
Ethics Clearance Expiry Date: October 18, 2024

Dear Miss Clark:

The Queen's University Health Sciences & Affiliated Teaching Hospitals Research Ethics Board (HSREB) has reviewed the application and granted ethics clearance for this study as of the date noted above.

Document Name	Comments	Version Date
Consent Form	Verbal LOI and Verbal Consent	2023/10/02
Recruitment Letter/Email/Notice/Poster	Recruitment Poster / Informational Study Poster	2023/10/02
Other document	Study ID log for individual's emails and numbers. Pseudonyms assigned if consented to sharing quotes. Email for co-analyses and member checking.	2023/09/05
Other document	Verbal Consent log to record consents.	2023/09/05
Interview Guide	Interview Guides for Circle (group) and One-to-one data collection	2023/09/05

Documents Acknowledged:

- Guiding Ethical Principles governing Indigenous partners/Community members
- Terms of Reference and MOU with Wahta Mohawks
- Budget for Wahta Mohawk in-community research
- Supervisor's letter/ e-mail of approval
- Research participants involved in study. Revised research community partners and governing partners.

Appendix D - Example Indigenous Community Research Budget

BUDGET December 2022- December 2023				
Study Title: Reconciling Indigenous Child and Family Health through Storytelling...				
ITEM (Direct Costs)	**RESEARCH ACTIVITY**	**COST ($CAD)**	**QUANTITY**	**TOTAL (CAD$)**
Fuel	P.I. researcher travel to First Nation community (by personal vehicle 425.0km one direction)	90	2 days	180
Meal Per Diem (travel)	meal allowance for in-community weeks	75	2 days	150
Recruitment/Study literature (printing)	literature for design/print of study materials	20	5 infocards	20
Elder/Knowledge Guardian honoraria	To support Elder(s) involvement and knowledge / guidance for research	90	6 hours	540
Community Gift (protocol)	Locally made gift/craft as part of protocol for relationship building	15	7 people	105
Chief Honoraria (protocol)	Locally made gift/craft	15	2 leads	30
Transcription Services	Storytelling sharing circles (2) transcriptions	120	5 hrs	600
Participant Honoraria	Feast meal for sharing story/research participation	25	20 people	in kind support
Accommodations (Daytime)	community-based field work at Community Centre at First Nation			in kind support
Office supplies (stationary/printing flyers)	study supplies/materials			in kind support
Traditional medicines for ceremonial openings	Protocol for sharing circles	~		in kind support
Laptop	Research study assigned laptop	2500	1	in kind support
Tablet	Data collection support (in-community)	1000	1	in kind support
IT Support/Software	Video conferencing platform/Zoom, Microsoft Office Suite, email, ethics support etc.)	~	duration of study	in kind support
Kettle	Ceremony research	50	2	in kind support
Feast Supplies	Ceremony research	200	community visits	in kind support
Tissues	Ceremony research	50	community visits	in kind support
Potable Water	Ceremony research	100	community visits	in kind support
Venue Rental	in-community Cultural Healing Centre	~	4 venues	in kind support
Doctoral Committee Guidance	Research Expertise	~	duration of study	in kind support
			Total Estimate	**1625**

Appendix D represents the estimated budget required to support reciprocal relationship-building through research partnerships. The research was supported by institutional, Principal Investigator/Researcher and by the Indigenous entity/Nation funding.

Appendix E: Storywork Analyses

Identity WHO WE ARE	Child & Family Health and Wellness CONCEPTUALIZING HEALTH	Wahta Mohawks Community SPECIFICS & GROWTH OPPORTUNITIES
• Traditional roles in relation to self-identity • Family roles • Community roles	Conceptually: • Community-specific values and principles • Wholistic approach to maintaining balance (mind, body, emotion, spirit)	Strengths • Traditional Mohawk/Kanienke:ha + Knowledges • 3-5 generations of Mohawk women in community • Dedication from staff in CHC to provide cultural roots in programming • Fluid, flexible approaches (learn from younger ones in early years program)
Diverse backgrounds • First Nations, Mohawk (Kanehsetake- Oka, Six Nations, Wahta), Innu • Non-Indigenous, Scottish	Practically: • Land-based - territory specific • Preventive approach to health and wellness • Community approach to health and wellness • Measures of health – culture, generational, relationships, social and prayer	Barriers • Isolated territory • Local attendance/engagement • Government determining access to based on identity • Colonial harms / "lies" in educational schooling • School off territory (Indian Residential School & mainstream school today) • Separation from family for schooling ages • Age barriers at community-led events
1. Family and/or community histories 2. Intergenerational traumas 3. Stressors 4. Community divides 5. Colonization 6. Internal emotions 7. Lifetime milestones 8. Community principles/culture	Health Values: 1. Indigenous community- Haudenosaunee/Mohawk Ways of Knowing, Being and Doing 2. Spirituality - Christianity 3. Mohawk (acceptance of identity as process) 4. Growth as a result of being in community territory 5. Storytelling 6. Resistance to Western health care modalities/systems/medicines 7. Parent/family supports 8. Plant-based medicines / traditional healing practices / community garden / calendar of moons cycle / food-sovereignty 9. Mindfulness / heart / gratitude 10. Flexibility	Opportunities 1. Autism & adaptive support services (early years) 2. Schooling on territory (formal & informal) 3. Access to Language (Kanienkeha) / culture 4. Concern for 7 Generations knowledge transfer 5. Develop local food sources / cooking methods 6. Learning across generations / reciprocally 7. Storytelling 8. Leadership training / Confidence training 9. Mindfulness exercises 10. Truth and Reconciliation programming 11. Building connections through program (male-centred, family centred, generational)

Appendix F: Research Agreement: Terms of Reference and Memorandum of

Understanding between Queen's University and Wáhta' Mohawks Chief and Council

Terms of Reference (TOR)

The TOR relevant to Wáhta' research partners: Wáhta' Mohawks – Chief Philip Franks and Council members and Departmental leads: Carol Holmes, Sandra Huxtable, Cortney Clark/Principal Investigator, and Queen's University Doctor of Science research project team members, (supervisory Academic Committee) regarding the community health and social research study, related to child, youth, and family health resources in community.

Purpose of the Research: The purpose of the research is to review the operations of the early learning and child/youth programs, as well as broader family-relevant community health supports to identify opportunities for future innovations that will improve the developmental and health services offered to individuals and families within the Indigenous community. The research will embody a holistic approach to understanding community-wide health and wellness priorities from a culturally informed perspective in community, with community. The research will be conducted in a phased approach, commencing the formal partnership in the fall of 2023, and the project will aim to be completed by January 31, 2024, to produce final reports and recommendations to community governing research partners no later than May 1, 2024.

Roles and Responsibilities: The community representative(s) lead the research partnership. They are involved in all stages of the research process, including the identification of research questions in the research circles, the development of research protocols, the engagement of research participants through the creation of the Community Advisory Circle, the interpretation of data, and the dissemination of research findings. The Doctor of Science P.I. Cortney Clark, will provide guidance and support in the research process, including Storytelling facilitation with guidance of Knowledge Keeper(s), collaborative data analysis and report writing. As well as liaise between the community-based research partners and the academic advisory project partners at Queen's University for the purposes of the doctoral program requirements.

Community Engagement: The community will be engaged in the research process through the establishment of a Community Advisory Circle (CAC). The CAC will include members of the community who have a vested interest in the child, family, and community health operations. The CAC will provide guidance and feedback on the research process, including the emergent nature of the semi-structured interview guide questions for discussion in the sharing circles, the emergent data analysis methods, and sharing of findings for improvements to the child, youth, and family health resources.

Data Governance: The research partnership honours shared data governance protocols between Wáhta' Mohawks and Queen's University representatives for the purposes of the Doctor of Science program requirements, dissertation presentations and (vetted by community) sharing/publication of study findings. Additionally, by virtue of a license back, Queen's University personnel reserves the right to access study data for quality assurance processes, such

as ethics, complaints and/or investigations throughout the formal study partnership. To ensure the protection of the privacy and confidentiality of research participants, the sharing circles (Storytelling circles) will follow protocols that include obtaining informed consent from the research participants, ensuring the anonymity of participants, and securing data storage and disposal in collaboration with Wahta Mohawks . All data will be subject to ownership, ethics review, and governance by Wahta's designated authorities, Chief, Council and/or departmental leads.

Dissemination of Findings: The research findings will be disseminated to the community through an Indigenous Knowledge Translation (ITK) community-based approach. The Doctor of Science project products will provide a summary report of the research findings that will be presented to the CAC, the health and social programming leaders and Chief and Council members. The leaders will be responsible for disseminating the findings to the broader community through community-based events, such as community gatherings, meetings, and newsletters, or however they deem appropriate, with support from P.I. Cortney Clark, if needed.

Ethical Considerations: The research partnership will comply with ethical principles and guidelines to ensure that the quality improvement study is conducted in a respectful, honest, and professional manner. The research will be guided by the principles of transparency, respect, reciprocity, relevance, and responsibility. The research will undergo Queen's University's institutional Health Sciences Research Ethics Board (HSREB) approval and abide by the s principles of ownership, control, access, and possession – more commonly known as OCAP® – to ensure that s have control over data collection processes, and that they own and control how this information can be used.

By adhering to these Terms of Reference, the research partnership between the Doctor of Science Rehabilitation and Health Leadership applied research project team at Queen's University, and Wáhta' Mohawks community will be conducted in a culturally appropriate and respectful manner, with the aim of improving the quality of culturally informed educational and developmental health services/resources offered to the children, youth, and families in the community.

Community Advisory Circle (CAC)

To ensure the privacy protection of the Community Advisory Circle (research partners) the Storytelling Circle (data collection) will inform the study and the following measures will be implemented:

Letter of Information and Informed Consent: Prior to the engagement in Storytelling, all members of the Community Advisory Circle (research participants) will be informed of the purpose of the research, their role in the study, and their rights as research participants. They will be provided with a consent form that outlines the research project, how the data will be collected and used, and the risks and benefits of participation. The consent form will also include information about the confidentiality of their personal information and the anonymity of their participation in the study. The lead researcher will be available for individualized and private consults with research partners that are/were employees at the community programs, or those

who prefer individual consultations. Verbal consent will be conducted and obtained in English language, as requested by community partners.

Anonymity and Confidentiality: To protect the privacy of the members of the research, all information collected during the Storytelling sessions will be kept confidential and anonymous. Personal identifying information such as names, addresses, and contact information will not be collected or recorded. Instead, pseudonym numbers will be used to identify the participants in the research through data analyses and dissemination phases.

Data Security: All data collected during the Storytelling sessions will be stored securely to protect the confidentiality and privacy of the participants on a research study-tablet. Data will be transferred to and stored on a password-protected computer with restricted access for the research leads. Any hard copies of the data will be stored in a locked cabinet at Chief and Council's discretion.

Data Retention: Data collected during the Storytelling sessions will be retained for the duration of the research project and will be securely governed and stored by the once the study is completed in May 2024. All data collected for the purposes of the applied research project parameters, will be stored securely by the lead researcher Queen's University for the duration of the study, and will be destroyed after 5 years in the institutional records by supervisor Dr. Janet Jull at Queen's University.

Ethics Approval: The research project has undergone formal ethics review processes to ensure that the privacy of the research partners/Storytellers are protected. The ethics approval has been obtained from the Health Sciences Research Ethics Board (HSREB) at Queen's University, that assessed the potential risks and benefits of the research project. The community partner will also review the agreements from their internal Leadership, Ethics and Legal review boards, as necessary.

Training: All members of the research team involved in collecting and analyzing the data have received training in culturally informed research ethics, confidentiality, and privacy protection.

By implementing these measures, we aim to ensure that the privacy of the partnering parties and Storytellers are protected while also gathering valuable information to inform the community health and social innovations.

Memorandum of Understanding (MOU)

MEMORANDUM OF UNDERSTANDING BETWEEN CORTNEY CLARK, DOCTOR OF SCIENCE CANDIDATE OPERATING UNDER AUSPICES OF QUEEN'S UNIVERSITY, UNDER THE GUIDANCE OF THE DOCTORAL ADVISORY COMMITTEE MEMBERS AND WAHTA MOHAWKS FIRST NATION PARTNERS (*CHIEF & COUNCIL & RESEARCH PARTNERS*).

Purpose: This memorandum of understanding (MOU) outlines the values and principles that will guide the data governance and community research engagement protocols for the study. The study benefits the partner community as we aim to better understand the educational and developmental health services/resources offered to the children, youth, and families in the community, to inform future opportunities and innovations in these realms.

This symbolizes the consenting partnership between QUEEN'S UNIVERSITY and WAHTA MOHAWKS PARTNERS. This MOU is intended to create a respectful and collaborative partnership between all research parties.

Values: The following values will guide the partnership between QUEEN'S UNIVERSITY and WAHTA MOHAWKS FIRST NATION PARTNERS:

1. Respect: We will treat each other with respect and consideration.
2. Listening: We will listen carefully to each other's perspectives and concerns.
3. Honesty: We will be honest and transparent in our communication and actions.
4. Professionalism: We will maintain high standards of professionalism in our conduct and work.
5. Honour: We will honour our commitments and obligations to each other.
6. Fairness: We will be fair and equitable in our decision-making processes.
7. Reciprocity: We will seek opportunities to share knowledge, resources, and benefits.
8. Relevance: We will ensure that the research is relevant and useful to the community.
9. Responsibility: We will take responsibility for our actions and their impact on the community.
10. Community-informed: We will involve and consult with the community, Elders, and leadership in all stages of the research process.

January 9, 2024
Prepared by: Cortney Clark (20cbc@queensu.ca)
STUDY TENTATIVE WORKING TITLE: *Reconciling Indigenous Health through Storytelling with a First Nation : Child, Family, and Community Health Study.*
CONFIDENTIAL DOCUMENT

10. Community-informed: We will involve and consult with the community, Elders, and leadership in all stages of the research process.

Community Research Engagement Protocol: The following protocol will guide the community research engagement process:

1. Identification of Community Research Needs: The community will identify its research needs through semi-structured Storytelling Sharing Circle research questions related to the health and social programming and operations study.
2. Partnership Development: CORTNEY CLARK et. (DSc Research committee members) AT QUEEN'S UNIVERSITY and WAHTA MOHAWKS FIRST NATION PARTNERS will develop a partnership agreement that outlines roles, responsibilities, and timelines.
3. Data Governance: Data governance protocols will be established to ensure that data is collected, used, and shared in a manner that respects the privacy, confidentiality, and security of the community.
4. Informed Consent: Informed consent will be obtained from participants in the study.
5. Community Engagement: The community will be engaged in all stages of the research process, including the development of research questions, data collection methods, and interpretation as well as sharing of results.
6. Dissemination of Results: The results of the study will be disseminated in a manner that is guided by, and accessible to the community.
7. Capacity Building: Capacity building opportunities will be provided to the community to enhance their knowledge and skills related to research and implementing culturally-informed theory to practice.

WAHTA MOHAWKS FIRST NATION- AUTHORIZATION BELOW:

Date: Feb 16/24 CHIEF

Principal Investigator (Cortney Clark) researcher under the auspices of Queen's University.

Signature: Cortney Clark

Date: January 9th 2024

5

Appendix G: Research Contributors

Contributors	Role
Principal Investigator	Myself, an Indigenous research candidate. Liaises between institution and indigenous nation for the study entirety
Academic Advisory Committee	Supervised doctoral candidate's research through representation of Queen's University
Indigenous Elders/Knowledge Keepers	Provide subject matter, expertise and support ceremonial aspects to research
Indigenous Community-based Research Partners	Storytellers and Community Advisory Circle (CAC)
Chief and Council	Indigenous governing authority on research project
CHC Leads	Manage CAC functions and support facilitation of research at community healing center

Appendix H: References

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